THE IMPACT OF ASSERTIVE TRAINING ON THE ANXIETY AND SYMPTOMIZATION OF WOMEN REFERRED BY PHYSICIANS

By

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To my parents.

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The purpose of this study was to investigate whether assertion training could effectively modify anxiety and symptomization in a population of women referred by their physicians. The women all reported anxiety of an interpersonal nature which they experienced symptomatically.

The sample for this study was composed of 82 female volunteers between the ages of 20 and 65 whose primary-care physician had suggested that they might benefit from participation in an assertion training group. They were women who, in the physician's estimation, were experiencing one or more of the following symptoms as a consequence of anxiety: somatic complaints such as headaches, gastrointestinal distress, dizziness and muscle soreness; indications of interpersonal sensitivity such as temper outbursts, feelings of

inferiority and of being critical of others; indications of depression such as loss of sexual interest or pleasure, poor appetite, crying easily or worrying and stewing about things; indications of anxiety such as feeling fearful, nervousness or shakiness inside, heart pounding or racing or feeling tense or keyed up.

These women were assigned to one of six treatment or six control groups. Members of the experimental groups were tested, received assertion training and were posttested. Members of the control groups were tested, waited seven weeks and were posttested. All training and testing was done by the researcher.

All 82 women provided all the data requested. Data consisted of scores on nine criterion variables: the Adult Self-Expression Scale, a measure of assertiveness; the A-State and A-Trait Anxiety Scales and the Hopkins Symptom Checklist, a clinical rating scale which reflects the psychological symptom configurations commonly observed among medical outpatients. The Hopkins Symptom Checklist yielded a total score and a score on five subscales (Somatization, Interpersonal-Sensitivity, Obsessive-Compulsive, Anxiety and Depression). Pre- and postscores on all of the instruments were totaled for all subjects. The women also completed a Personal Data Form. The members of the experimental group filled out a form evaluating the training during the posttesting period.

Chi square analyses were used to evaluate the differences between the treatment and the control groups on the demographic data. Group assignment was shown to be independent of the personal data variables.

Analyses of covariance, using pretest scores as covariates, were used to evaluate each of the nine scale scores. The analyses produced results significant at the .05 level for all variables except the Depression subscale of the Hopkins Symptom Checklist. Means and standard deviations were computed for the evaluation form items.

Based upon these statistical findings the assertive training group was better than the control group in developing assertive behavior, in lessening general and situation-specific anxiety and in lessening the women's somatization, obsessive-compulsivity, interpersonal sensitivity, anxiety and total symptomization.

CHAPTER I

INTRODUCTION

There are several clear indications that managing or coping with anxiety and stress is a problem for a large segment of the population today. From the volume of anxiolytic drugs prescribed, it is clear that physicians are aware of anxiety in their patients. Surveys (e.g., Greenblatt & Shader, 1974) have shown that approximately 15% of adult Americans regularly take antianxiety agents on an outpatient basis. This suggests that anxiety is prevalent and that physicians commonly resort to pharmocotherapy to provide relief for these symptoms.

A second major indicator of the prevalence of anxiety as a problem in our society is that professional counselors, "self-help" techniques and a number of popular psychology books aimed at adjustment problems are widely accepted and utilized. A recent analysis of the new "self-help" phenomenon identified self-awareness as a new panacea: "Across the country, Americans are frantically trying to 'get in touch' with themselves, to learn how to 'relate' better, and to stave off outer turmoil by achieving inner peace" (Schur, 1977). Our culture actively encourages people to seek out solutions to their problems and to seek self-fulfillment in the process. Accordingly, it has provided these

methodologies to help individuals deal with the anxiety and turmoil such searches can precipitate.

Anxiety is difficult to define precisely. Since stresses change and situations vary, anxiety is usually episodic as opposed to static. Often related to environmental stresses or specific situations the individual considers threatening, anxiety may trouble a person for a while and then dissipate until the individual encounters further stresses. Accordingly, Spielberger (1966) distinguishes between two types of anxiety. Trait anxiety refers to anxiety levels and proneness that are relatively stable. High trait anxious persons are predisposed to respond anxiously to a wide range of stimuli (or situations) that they perceive as threatening or dangerous. Because it is relatively constant, this type of anxiety has a pervasive effect on individuals' lives. Time-consuming and often costly treatments are generally required to achieve lasting solutions to the problems trait anxiety precipitates.

This study addresses the issue of trait anxiety and Spielberger's other type of anxiety - state anxiety. State anxiety refers to a temporary condition or state that may vary in intensity and fluctuate over time in response to circumstances that an individual perceives as threatening (Spielberger, 1966). In contrast to the trait anxious person who characteristically responds in an anxious manner (often even when unprovoked), an individual's experience of state anxiety can frequently be connected to identifiable stressful events or situations. Accordingly, the treatment of state anxiety is generally of shorter duration.

Need for the Study

Although common to both sexes, available data support the view that anxiety is particularly a problem for women. Women consistently report more symptoms of anxiety and emotional distress than men (Balter, 1973). Cooperstock (1976) confirms that women exceed men in their consumption of psychotropic drugs in a consistent ratio of two to one.

Many women fail to make a connection between the stresses and problems in their environment and their vague, often subjective impressions of anxiety (Williams, 1977). It is very often this failure to recognize why they are anxious that makes it difficult for women to cope with anxiety.

Several factors seem to be especially significant in discussing why women are anxious. Contemporary thought holds that changes in their role in society have resulted in increased stress and anxiety for women in particular (Cooperstock, 1976). Stresses arising from potentially conflicting social roles (for example, wife, mother, worker) and pressures from multiple roles are creating problems for women that lead to more anxiety. Women today are caught between conforming to existing standards or role definitions and exploring the promise of new alternatives.

Women today also are confronted with an increasing awareness and concern about personal limitations and the desire to overcome them (Lange & Jakubowski, 1976). They feel anxious, for example, when the "women's movement" stimulates them to grow while they feel unprepared to fulfill these aspirations. Jakubowski-Spector (1973) points

out that as women assess their individual potentials for self-growth, they often notice inadequacies in their abilities to assert their personal rights. Moreover, anxiety about interpersonal conflicts often inhibits their trying out new roles and seeking new relationships. Thus, many women are caught in the paradoxical situation of experiencing anxiety within their existing situations or roles (trait anxiety) and at the same time experiencing anxiety (state anxiety) as they try out new behaviors which might alleviate those anxieties.

Anxiety, however, can be treated. Although it is generally considered a psychological phenomenon, many individuals first manifest anxiety symptomatically, varying from somatic complaints such as headaches or insomnia to direct indications of anxiety such as feeling fearful or nervous. Since these complaints may be the only distress individuals actually feel, the primary-care physician is often the first professional they approach for treatment. Because of the physician's medical orientation, the treatment often takes the form of drug therapy. This can be expensive and in some cases debililating. Frequently a drug which eliminates a person's anxiety also causes side effects such as drowsiness or impairment of psychomotor functions, thereby reducing the patient's overall functioning (Greenblatt & Shader, 1974). Moreover, treating the symptom or somatic manifestation of the anxiety without helping the patient identify and learn to cope with the anxiety-provoking situation generally does not result in effective behavior change.

Historically the psychological treatment of anxiety has involved extended and intensive psychotherapeutic relationships. Such methods are expensive and time-consuming and therefore generally unavailable to the vast majority of people. Chesler (1971) has suggested that for many women the psychotherapeutic encounter is just one more power relationship in which they are rewarded for expressing distress and are helped by submitting to a dominant authority figure, thereby creating more anxiety.

Self-help methods, on the other hand, are popular and inexpensive but at the same time unguided. Thus, there exists a strong possibility that the use of such methods may in fact produce even more anxiety. Indeed this possibility seems likely, since by definition state-anxious individuals are ineffectively using self-directed behaviors.

Some of the more recent professional counseling methods have potential applicability to the treatment of anxiety. They are generally less expensive, threatening and time-consuming and more socially acceptable. Some of these, such as encounter and sensitivity groups, Transactional Analysis and communication skills have enjoyed immense popularity. However, most of these methodologies are based upon the principle of increasing self-awareness and not specific adaptive behaviors. Therefore, there is a need for methods which emphasize situational applications and help individuals focus emotional energy toward alleviating specific difficulties or problems.

One of these methodologies, assertion training, is especially useful in this regard. It has a long history, but only recently have

professionals and the lay public become interested in it. Lange and Jakubowski (1976) attribute this current interest to two important cultural changes which seem to have taken place in the sixties. First, as it became more difficult to achieve a feeling of self-worth through more traditional sources, such as work and marriage, people began to value their personal relationships as a major source of life satisfaction. Many individuals sought to improve the interpersonal skills necessary to better their personal relationships and to overcome the anxious feelings inhibiting the expression of needs. Second, as the range of socially acceptable behaviors widened and alternative lifestyles became more acceptable, many people found themselves unprepared and anxious about either making choices about how to behave or defending their choices when criticized or challenged by other people.

Assertion training has thus become a means for helping people deal more effectively with many problematic aspects of their lives. Since many of these problematic aspects of peoples' lives are anxiety producing, assertion training has the potential to alleviate or prevent some instances of state anxiety experienced when trying out new behaviors and trait anxiety with its more pervasive influence. It would follow then that assertive training might also alleviate some of the symptomatic manifestations of this anxiety.

Assertive behavior has been defined as any interpersonal response involving the direct, honest and appropriate verbal and nonverbal expression of one's feelings, beliefs and personal rights, without violating the rights of another person (Rimm & Masters, 1974).

Assertion training, then, is any procedure which incorporates the goal of increasing an individual's ability to engage in such behaviors in a socially appropriate manner (Jakubowski-Spector, 1973). Although at thepresent time there is a lack of general agreement about which specific procedures actually constitute assertion training, the process generally incorporates four basic procedures: (1) teaching people the difference between assertion and aggression and between nonassertion and politeness; (2) helping people identify and accept both their own personal rights and the rights of others; (3) reducing existing cognitive and affective obstacles to acting assertively, e.g. irrational thinking, excessive anxiety, guilt and anger; and (4) developing assertive skills through active-practice methods (Mize, 1975).

A number of variables appear to be theoretically or conceptually related to assertion. These include locus of control, self-confidence, personal adjustment and anxiety. Research has been carried out showing that as individuals become more assertive, manifest anxiety decreases (Percell, Berwick & Beigel, 1974), while self-confidence (Gay, Hollandsworth & Galassi, 1975) and personal adjustment (Galassi & Galassi, 1974) increase. The assumption here is that assertion training also should be effective in reducing the levels of state and trait anxiety in women, and that if such a reduction occurs the level and intensity of symptomatization will also be reduced. Since being nonassertive, having ineffective interpersonal relationships and lacking identity almost always result in an individual being anxious, women who have these problems might be helped by assertion training.

Purpose of this Study

The purpose of this study was to determine whether assertion training, using well-defined and researched procedures, can effectively reduce anxiety in a unique population of women who experience symptoms of that anxiety. The Percell et al. (1974) study showed that assertion training with a small (12 treatment and 12 controls) mixed-sex group of psychiatric outpatients did successfully reduce anxiety as measured by the Taylor Manifest Anxiety Scale. The present study examined the relationship between assertion training and general feelings of anxiety. It also looked at the relationship between assertion training and those feelings of anxiety specific to the time of the assertion.

Two unique features of this study are: (1) its population of normal women (not a student group and not a psychiatric inpatient or outpatient population) referred by their physicians; and (2) its examination of the relationship between assertion training and symptomization.

If it can be shown that this particular technique does in fact significantly increase assertion and decrease anxiety and symptomization, then we have an effective methodology that is (1) socially acceptable, (2) easily taught and (3) relatively easy for participants to understand and learn.

Plan of the Study

Subjects for this study were women between the ages of 20 and 65 whose primary-care physician suggested they might benefit from participation in an interpersonal skills training group. The women

reported situational anxiety of an interpersonal nature which they experienced symptomatically. The physicians were briefed on the nature of the treatment and suggested participation on the basis of the above criteria.

Hypotheses

The following null hypotheses were tested:

Hypothesis 1: There is no difference in women's level of assertion as a result of participation in an assertion training group.

Hypothesis 2: There is no difference in women's level of state anxiety as a result of participation in an assertion training group.

Hypothesis 3: There is no difference in women's level of trait anxiety as a result of participation in an assertion training group.

Hypothesis 4: There is no difference in number and intensity of symptoms expressed by women as a result of participation in an assertion training group.

Definition of Terms

Terms relative to this study are defined below:

Assertive Behavior

Assertive behavior is interpersonal behavior involving the honest and straightforward expression of feelings. The main component of

assertive behavior may be divided into four separate and specific response patterns: the ability to say "no", the ability to ask for favors or make requests; the ability to express positive and negative feelings; and the ability to initiate, continue and terminate general conversations (Lazarus, 1973).

Assertive Training

Assertive training is a therapy technique used with individuals who are inhibited, shy and therefore unable to express themselves in situations where assertion is called for. For example, they are unable to speak up for themselves when they feel they are being taken advantage of and are also unable to express positive feelings such as pleasure or affection when this is appropriate. The purpose of assertive training is to increase the individual's ability to express these feelings.

Behavioral Assignments

The assertiveness trainer makes behavioral assignments which call for the client to involve herself in interpersonal encounters in the environment outside the group sessions. The client attempts to use assertive behaviors in these encounters.

Behavioral Rehearsal

Behavioral rehearsal is role playing the desired assertive behaviors the client must use in interpersonal encounters in her life.

Primary-Care Physician

Primary care is basic or first contact care. It is the care of common disorders. Provision of primary care is usually the function of the family practicioner, internist, gynecologist or pediatrician.

Psychotherapeutic Drugs

Psychotherapeutic drugs are those mood-changing drugs generally used for the treatment of mental disorders or for the alleviation of symptoms of psychic distress, and are typically acquired through prescription channels (Parry, Balter, Mellinger, Cisin & Manheimer, 1973).

CHAPTER II

REVIEW OF THE LITERATURE

Anxiety

Anxiety as a Problem

Today's society is plagued by numerous stresses which serve to induce feelings of helplessness and impotence. Social and cultural factors, such as the persistent threat of total destruction in an atomic age, the social change which occurs in the wake of rapid scientific and technological advances, and the social estrangement and alienation of individuals in a competitive society, combine to undermine feelings of personal security and contribute to increased feelings of anxiety (Spielberger, 1966).

There are several clear indications that anxiety is a pervasive psychological phenomenon in modern society. One of the most clear-cut of these indicators is the widespread use of anti-anxiety agents. Such usage is increasing at an alarming rate, with one in ten Americans taking these drugs during any three month period. This puts the yearly cost at greater than two hundred million dollars (Greenblatt & Shader, 1974). A long-term research program on the extent and character of psychotherapeutic drug use in the United States (sponsored by the Psychopharmacology Research Branch of the National Institute of Mental Health) reported that in 1972 almost 215 million

prescriptions for psychotherapeutic drugs were filled in United States drugstores. This was 16% of the 1,400,000,000 prescriptions filled that year. Approximately 44% of these prescriptions for psychotherapeutic drugs was accounted for by a single class of drugs - the anti-anxiety agents (Balter, 1973). More recently, National Prescription Audit results indicated that Valium, a minor tranquilizer, was the most prescribed drug in 1976 (2.5% Increase ..., 1977). The fact that 75 to 80 percent of all psychoactive drugs prescribed by physicians in private practice were prescribed for the purposes of sedation, tranquility or sleep (Balter, 1974) would indicate that many individuals come to physicians with problems that require calming down.

Another manifestation of anxiety in contemporary life is the widespread public pursuit of psychological happiness and fulfillment. This quest is clearly evidenced by the current proliferation of mass-distributed personal guidance books. Books which provide insight, challenge people to grow emotionally, and profess to actually teach the skills necessary for happiness and fulfillment have received widespread acceptance. Passages, which elucidates predictable crises faced by men and women as they move through adulthood, was on the New York Times Review hardback best-seller list for 49 consecutive weeks (Publishers Weekly, June 27, 1977, p. 82). Your Erroneous Zones, described by the New York Times Book Review as a "self-help pep talk" has been on the hardback best-seller list for 54 consecutive weeks. And Looking Out for Number One, a compilation of tips and practical suggestions unified by a basic

philosophy of self-interest, joined the best-seller list just two weeks after its publication (Publishers Weekly, June 27, 1977, p. 118). This phenomenon, along with the increasing number of centers and organizations offering workshops on every topic from sexuality to separation and divorce, points to peoples' need to resolve the turmoil in their lives.

Types of Anxiety

Anxiety has been defined as "a fearful and apprehensive emotional state, usually in response to unreal or imagined dangers, that interferes with favorable and effective solutions to real problems. Anxiety is typically accompanied by somatic symptoms that leave one in a continuous and physically exhausting state of tension and alertness" (Psychology Today: An Introduction, 1972, p. 720).

Anxiety usually expresses itself in one of two ways. An individual may be considered to be either (1) generally anxious or (2) anxious because of particular circumstances. The two conditions reflect entirely different interpretations of the construct, anxiety. The former refers to a relatively constant condition without time limitation, whereas the latter implies that the anxiety is immediate and most likely temporary. Usually these two types of anxiety are referred to as chronic and acute.

Acute as a descriptive term is used most often when describing a pathological anxiety state. Generally the phrase "acute anxiety attack" is used in referring to the severely stressed person who often requires psychiatric care. Usually, when speaking about the noticeable, but lesser, anxiety of a more normally stressed individual, the terms situational or transient are used (Levitt, 1967).

The term chronic anxiety also needs explanation. Usually when the word chronic is used to described a state or condition it is interpreted to mean a condition of relatively low intensity or indefinite duration. When applied to an emotional condition like anxiety, however, what is actually meant by chronic is a high proneness or predisposition to experience anxiety. Individuals who are considered chronically anxious are identified not by the intensity or degree of their anxiety but by the number of occurrences and objects which evoke a detectable degree of anxiety in them. It follows that anxiety-prone individuals are predisposed to respond anxiously more frequently and in a wider variety of situations than their peers (Levitt, 1967).

The distinction between acute or situational anxiety and anxiety-proneness or predisposition has been delineated by Spielberger (1966). Situational anxiety is defined as a transitory state that occurs in response to a stimulus (generally circumstances that are preceived as threatening) and is likely to vary in intensity and fluctuate over time. Anxiety-proneness is conceptualized as a personality trait. Trait anxiety refers to relatively stable individual differences in anxiety level. The high trait anxious individual is predisposed to respond with an anxiety state reaction to a wide range of stimulus situations that are perceived as threatening or dangerous (Spielberger, 1966). This study concerns itself with both state and trait anxiety.

Anxiety as a Problem for Women

Although common to both sexes, available data support the view that anxiety is particularly a problem for women. Prevalence rates for the use of medically prescribed therapeutic drugs are substantially higher for women than for men (29% compared to 13%) (Balter, 1973). Current patterns of use suggest strongly that most of the difference in rates between men and women can be accounted for by a single broad class of psychotherapeutic prescription drugs - the minor tranquilizer/sedative group.

Parry et al. (1973) discuss certain tentative explanations of these differences which were uncovered by the NIMH study of psychotherapeutic drug use in the United States: (1) A visit to a physician is generally the first step in acquiring psychotherapeutic prescription drugs. In this sample women were significantly more likely than men to report visiting a physician in the year preceding the survey: a total of 58% of the women compared to 46% of the men. (2) Male prevalence rates for drugs such as alcohol and marihuana were substantially higher than female rates, indicating that these psychotropic substances may serve as substitutes for the prescription psychotherapeutics for men. (3) Women in our society, particularly middle-aged and older women, are permitted and often encouraged to have mild symptoms of psychic distress and to see a doctor for them. (4) Women are more likely to report higher levels of psychic distress. They are also more likely to report having undergone specific situational stresses. (5) Women were significantly more likely than men to take a tranquilizer in advance of a possibly unpleasant event.

In addition to the societal and psychological factors, Parry et al. (1973) mention some definite physical factors which might explain why women take more psychotherapeutic drugs than men. First, males do not go through the oestrous cycle (pregnancy, childbirth and menopause) which could increase a woman's chance of receiving psychotherapeutic drugs. Secondly, normal actuarial patterns indicate a wife will survive her husband. Since culture dictates that women mourn more openly than men, prescribing of a minor tranquilizer, sedative or hypnotic for this situation is commonplace (Parry et al., 1973).

The literature suggests several other factors which seem to be especially significant in discussing why women are anxious. Gove and Tudor (1973) maintain that role expectations confronting women are generally unclear and diffuse. In this culture the notion of what it means to be female inevitably suggests some type of submissive role (Osborn and Harris, 1975), yet women can clearly see that what society values are the norms of the male culture - being assertive, autonomous, competitive and achieving (Walstedt, 1974). Walstedt (1974) maintains that women are marginals in our society, living on the margin of two cultures, never socially or psychologically a part of either. "Females are schooled from birth into the more highly valued norms of the male culture ... but they are also taught to be helpful, unassertive, dependent ... girls are drawn to the more powerful and rewarding masculine world even as they are also learning to accept as natural that they should never enter the world. The clash of two possible self-definitions is usually experienced by girls and women as undifferentiated feelings of frustration, anxiety or discontent" (Walstedt, 1974, p. 640).

Another significant factor to be considered when discussing why many women experience anxiety is that most adult women are employed outside of the home: they constitute 40% of the paid labor force (Seiden, 1976). Statistically, they hold lower status, lower-paying jobs than do men, which often poses psychological if not economic problems for them. Another source of anxiety, closely tied to the fact that more women are working, is their feelings of guilt about or very real conflict between the demand of occupational roles and maternal roles. Contemporary American society relies primarily on mothers alone for child care, expecting little participation by older children, husbands or other relatives (Gove & Tudor, 1973; Seiden, 1976).

These assumptions are not, however, without challenge. For example, Cooperstock (1976) disagrees with the speculation that having a number of social roles such as wife, mother and worker creates stresses for women that lead to more problems and perhaps even to an increase in the use of psychotropic drugs. "The evidence to date suggests that contemporary women filling numerous roles have somewhat less illness and take fewer tranquilizers and sleeping medications than women filling the traditional female role of housewife" (Cooperstock, 1976, p. 763). Nathanson (1975) concluded that "employment has perhaps the most positive effect on women's health of any variable investigated to date" (Nathanson, 1975, p. 60). She cited studies showing that working women present fewer symptoms than nonworking women of the same age, and report fewer days of disability and less anxiety.

The woman who chooses not to work outside the home is faced with a unique set of stresses. Housewives frequently have no alternative sources of gratification outside the family (Gove & Tudor, 1973) and are frequently isolated from other adults (Seiden, 1976). Housework is unskilled and low in prestige, and the housewife role is relatively unstructured, leaving much time available for women to worry about their problems (Gove & Tudor, 1973).

The current "women's movement" has focused attention on most of these factors which potentially contribute to women's anxiety. In doing so it has helped women in their personal struggles for fulfillment. But, for others,the challenge to change and grow has created new feelings of frustrations and anxiety. They feel anxious, for example, when the "women's movement" stimulates them to grow while at the same time they feel unprepared for change. Moreover, anxiety about interpersonal conflicts often inhibits their trying out new roles and seeking new relationships. Thus, many women are caught in the paradoxical situation of being anxious about their existing situations or roles (experiencing trait anxiety) and at the same time being anxious (experiencing state anxiety) as they try out new behaviors which might alleviate those anxieties.

Treatment of Anxiety

Medical Approaches

Anxiety can be treated. Although it is generally considered a psychological phenomenon, many individuals first manifest anxiety in a somatic manner. Patients often come to their physicians with a

somatic complaint which may in fact be the only distress they feel. Many, however, hope such a complaint will be more acceptable, or taken more seriously, than the actual reason for their visit which may be an unstated constellation of their fears and anxieties (Geyman, 1977). Because of the physician's medical orientation, treatment of anxiety frequently involves the prescription of psychotherapeutic drugs. These drugs are often prescribed in cases where a physical condition may have been caused by, be further aggravated by, or perhaps result in anxiety (Parry et al., 1973).

Caster (1977) differentiates anxiety into four distinct categories: (1) anxiety neurosis, (2) situational anxiety, (3) anxiety as an aspect of disease,and (4) psychophysiologic disorders. He defines anxiety neurosis as a recurring emotional state without recognizable etiology which is manifested by apprehension, fearfulness or a sense of impending doom and is associated with autonomic nervous system discomfort. Situational anxiety is identified as that of an individual of relatively normal emotional background whose anxiety is provoked by identifiable stressful life events. Anxiety as an aspect of disease is a specific example of situational anxiety where anxious feeling is related to consequences of the illness. Psychophysiologic disorders are considered to be conditions in which emotional factors, particularly stress, play either an etiologic or perpetuating role. An example of a psychophysiologic disorder is a peptic ulcer.

The use of antianxiety agents in these four different groups of disorders will vary depending upon the specific conditions as well as other external events such as the availability of alternate treatment modalities. Lader (1976) suggests that when a patient complains of anxiety the physician should first try to establish its cause. Often there will have been a change in the life circumstances of the patient which has precipitated the anxiety symptoms. If the underlying cause can be readily identified, treatment is directed towards modifying these factors so as to lessen the pressures on the patient. If it is not possible to identify a cause, the physician frequently resorts to symptomatic relief with drugs.

It is important to ascertain whether the patient has suffered from life long "personality" anxiety or whether the present episode has occurred in a previously calm individual (Lader, 1976). The former patients may need long-term treatment and psychological support. Since many of these disorders tend to be chronic, reliance on drug therapy could prevent patients from dealing realistically with their living situations. The use of antianxiety agents is not the treatment of choice for those who could benefit from therapy leading to behavioral change (Caster, 1977).

These latter patients experience the equivalent of Spielberger's state-anxiety. Their symptoms will probably subside of their own accord and then recur when the patient once again encounters a stressful situation. The rationale for psychotherapeutic drug use with

these patients is to tide them over a bad time (Lader, 1976). Greenblatt and Shader (1974) make the point that since anxiety in these cases is most often an episodic disorder, drug therapy is most reasonable when it coincides with the exacerbation of symptoms. Dosages can be increased when discomfort is most severe and reduced or eliminated during remission. Patients are often encouraged to make these adjustments themselves.

Patients experiencing state anxiety can be further differentiated. For instance, a patient receiving medication to deal with a single episode crisis situation of short duration (e.g., an accident, death, grief, divorce) is different from a patient receiving periodic doses of medication to improve functioning or living in recurrent situations (e.g., meeting deadlines, coping with emergencies, or, especially in the case of women, dealing with the effects of unresolved anger) (Cline-Naffziger, 1974). Both of these cases are quite different from the patient who uses medication to offset anxiety or discomfort (e.g., fear of the dentist, fear of confronting other people). It seems important to make the distinction that where medication might, in fact, be all that is necessary in the first case, the others might yield greater benefit from therapy aimed at bettering their coping skills.

A large proportion of psychotropic drug prescriptions are written by family practitioners. Even though psychiatrists and neurologists generally prescribe at higher dosages when they employ these agents, greater numbers of prescriptions are actually written by family physicians (Hesbacher, Rickels, Rial, Segal & Zamostien, 1976). This

physician group accounts for 50% of the total psychotherapeutic drugs prescribed (Balter & Levine, 1971). It must be remembered that while family practitioners represent only 31% of all physicians, they account for 38% of all patient visits (Balter, 1973).

The family physician and other primary-care physicians have an involvement with emotional problems that is markedly different from the psychiatrist's experience, which frequently involves the management of severe psychiatric disorders in a hospital or crisis intervention setting. Primary-care physicians see a wide range of less severe and often situational emotional problems in their everyday practice, including anxiety reactions, psychosomatic disorders, grief reactions, school problems, sexual and marital problems, etc. Patients with these types of problems are frequently troubled in a more general and nonspecific way. Unfortunately, the pressure is on the doctor to produce a quick cure. Faced with a busy schedule it is often just easier to write out a prescription for a tranquilizer than to listen to the patient's problems (Watts, 1976; Muller, 1972).

The potential negative aspects of such a system of dealing with anxiety are numerous. The presence of side effects (Muller, 1972; Greenblatt & Shader, 1974) such as drowsiness, could reduce the patient's overall level of functioning. Moreover, treating the symptom without helping the patient identify and learn to cope with the anxiety-provoking stimuli does little to promote effective behavior change.

Job, marriage, and financial problems are areas patients frequently cite as common sources of anxiety (Williams, 1977). Cooperstock

(1976) interprets a physician's involvement in these problem areas as an expansion of the bounds of medical care. She eyes such expansion critically. "If financial difficulties, loneliness, and disobedience of children are common problems presented to physicians, then it is hardly surprising that psychotropic drug consumption has increased so much during the past decade" (Cooperstock, 1976, p. 761). The medical model has expanded to encompass more aspects of our lives. Critics of this change claim that physicians are trying to treat "social pathologies rather than medical illnesses when they prescribe psychotherapeutic drugs" and they assert "the more common personal, social, and family problems of everyday life are being labeled as illnesses and treated by drugs" (Balter, 1973, p. 59).

Psychological Approaches

Self-help approaches. Reflecting our country's long-standing emphasis on individualism, current self-help books emphasize what might be called psychological success (Schur, 1977). Lewin (1977) maintains that though these self-help methods differ in catch phrases or styles they seem to share certain values. (1) The most important objective in life is the happiness and fulfillment of the individual who is reading the book. (2) Other peoples' wishes and needs are important only to the extent that they contribute to the well-being of the reader. (3) Guilt is considered an inappropriate response which the person must work to dispel. (4) Selfless involvement in social causes is considered bad unless it enhances one's personal fulfillment. These values seem very oversimplified. They hold

individuals completely responsible for their lives and tend to overlook the person's interaction with the social environment.

Self-help methods are popular but at the same time unguided. All too often they are simplistic approaches to human behavior. They give people the idea they can easily do things they often cannot. Farson (1977) claims that by offering fulfillment, communication, effective childrearing practices, etc., these methodologies frequently set up standards that individuals will never be able to meet. Raising expectations creates a discrepancy between what persons feel they might have and what they do have. This disparity can frequently be a source of anxiety rather than an effective treatment for it.

Traditional approaches. There is disagreement among therapists about which therapeutic approach or technique is best for treating anxiety. Therapists choose those therapeutic techniques which best reflect their theories and philosophies.

Anxiety plays a central role in psychoanalytic theory. Generally, it is thought of as a product of guilt produced by repressed early learning experiences. Anxiety is likely to occur when the ego (according to Freudian theory, that part of the psyche that handles transactions with the external environment) receives threats from the environment, the id (the unconscious and most primitive part of the psyche comprising drives, needs and instinctual impulses), or the superego (the partially unconscious part of the psyche which incorporates parental and social standards of morality). The function

of anxiety is to warn persons of impending dangers so that they may do something to avoid them. Frequently the ego responds to the pressure of anxiety with defense mechanisms which operate unconsciously and deny, falsify or distort reality. Therapeutic methods of the analyst would most likely involve helping the client develop insight by conjuring up painful past experiences. The therapist is aware of the interplay of unconscious forces and the way in which they affect the person's symptoms. The crux of therapy is to share with the client full insight into his unconscious (Psychology Today: An Introduction,1972; Stefflre, 1965).

Rational-emotive therapy operates on the assumption that emotions are largely controlled by cognitive, ideational processes. It holds that an individual's emotions and motivations represent learned reactions. These can potentially be reviewed, modified and reconstructed by the individual. The rational-emotive therapist would likely view anxiety as a result of irrational thoughts clients were telling themselves were true. Therapeutic techniques would involve actively pointing out the client's irrational thoughts and challenging their soundness as well as getting the client to try out alternate ways of thinking (Blocher, 1966).

The client-centered therapist holds that all behavior is a function of an individual's perceptions at the moment. People perceive what is appropriate for persons with their self-concepts to perceive. Anxiety is generated when the person's perception of himself, his self-concept, is incongruent with his actual

experiences. When an individual's self-concept is threatened, his field of perception is narrowed and distorted. In counseling, the therapist seeks to reduce threat and remove it as an obstacle to clearer perceptions and more effective behaviors. The establishment of a relationship in which the counselor experiences feelings of unconditional positive regard and is genuinely empathic and understanding of the client's internal frame of reference is the prime goal of the therapist. Having established a warm, accepting and permissive counseling environment, the counselor seeks to facilitate the client's own self-exploration by reflecting and clarifying his self-referent feelings and statements (Blocher, 1966; Stefflre, 1965).

The theories described above are representative of traditional psychological approaches to anxiety. They reflect the fact that the psychological treatment of anxiety has historically involved extended and intensive psychotherapeutic relationships. Such methods are often expensive and time-consuming and, though generally required to achieve lasting solutions to the problems trait anxiety precipitates, they are not usually necessary when dealing with state anxiety.

Equally important here, however, is the fact that conventional forms of psychotherapy have been criticized in terms of their applicability to women. Most significant seems to be the criticism that psychotherapy encourages women to talk rather than act. This talking tends to diffuse emotion and fails to involve the women in any reality-based confrontations with the self (Chesler, 1971; Seiden, 1976). Chesler (1971) also has suggested that for women the

psychotherapeutic encounter is just one more power relationship in which they are rewarded for expressing distress and are helped by submitting to a dominant authority figure, thereby creating even more anxiety.

Behavior Therapy Approaches. Some recently developed counseling methods have potential applicability to the treatment of anxiety. These are generally less expensive, threatening and time-consuming, and in many cases more well-known than traditional therapeutic approaches. Some of these, such as encounter and sensitivity groups, Transactional Analysis and communication skills training have enjoyed immense popularity. However, most of these methodologies are based upon the principle of increasing self-awareness, not specific adaptive behaviors. There are, however, alternatives to these theories and techniques in the field of learning theory and behavior therapy.

In the language of S-R reinforcement theory, "fear or anxiety is a learned or acquired emotional reaction to originally neutral stimuli which were presented a number of times together with a noxious or painful stimulus" (Stefflre, 1965, p. 147). Behavioral therapists who advocate a direct approach to the elimination of anxiety generally manipulate the client's environment directly, either in the therapist's office or in the outside world, to produce anxiety reduction. A procedure such as systematic desensitization is representative of this direct approach to anxiety relief (Stefflre, 1965).

The more direct or behavioral training approaches to psychotherapy are based on a response acquisition model of treatment. "Within this model, maladaptive behaviors are construed in terms of the absence of specific response skills. The therapeutic objective is to provide clients with direct training in precisely those skills lacking in their response repertoires. Very little attention is given to eliminating existing maladaptive behaviors, instead, it is assumed that as skillful, adaptive responses are acquired, rehearsed and reinforced, the previous maladaptive responses will be displaced and will disappear" (McFall & Twentyman, 1973, p. 199). A therapeutic procedure which exemplifies this indirect behavioral approach to anxiety is assertive training. Assertive training considers the extinction of anxiety as a by-product of teaching clients how to behave in an assertive manner within the nonpunitive atmosphere of a counseling relationship.

Assertive Training

Assertive behavior is interpersonal behavior involving the honest and straighforward expressing of feelings. The main components of assertive behavior may be divided into four separate and specific response patterns: the ability to say "no"; the ability to ask for favors or make requests; the ability to express positive and negative feelings; and the ability to initiate, continue and terminate general conversations (Lazarus, 1973).

Assertive training is a therapy technique which is used with individuals who are inhibited, shy and therefore unable to express themselves in situations where assertion is called for. For example, they are unable to speak up for themselves when they feel they are being taken advantage of and are also unable to express positive feelings such as pleasure or affection when this is appropriate. The purpose of assertive training is to increase the individual's ability to express these feelings.

Historical Antecedents of Assertive Training

The work of Andrew Salter played an important role in the development of the current conceptualization of assertive training. Salter (1961) applied the conditioning principles of Pavlov to the full spectrum of neurotic behaviors (Wolpe, Salter & Reyna, 1965, p. 114). People, according to Salter, are born "excitatory." As individuals develop, many of their excitatory responses are paired with punishment and they become inhibited. Those inhibited response patterns which are conditioned during childhood may remain in a person's adult life. For Salter the goal in therapy is the "unlearning" of these inhibited responses through the reconditioning of faulty inhibitory patterns of earlier life. He equates mental health with the attainment of emotional freedom and advocates excitatory procedures for virtually every conceivable psychological disorder and for all those clients seen as suffering from inhibition. "The happy person does not waste time thinking. Self-control comes from no control at all. The excitatory act, without thinking. The inhibitory think, without acting, and delude themselves into believing that they are highly civilized types" (Salter, 1949, p. 42).

Salter's therapeutic techniques are implemented to increase excitation through verbalization. Pauses and silences are not valued since excitation is desired, not insight. The first technique is called feeling talk. Using feeling talk means spontaneously expressing felt emotions, being truthful and emotionally outspoken. The second rule of conduct, facial talk, refers to the congruence between one's emotions and facial expressions. The third technique is to contradict and attack. When individuals differ with someone they should freely express their true feelings and not pretend to agree. The fourth technique requires the deliberate use of the word I as much as possible. The fifth technique is to express agreement when praised and to volunteer praise of self. Improvisation, the sixth and last rule of conduct, refers to being completely spontaneous (Salter, 1949, p. 100).

Salter is not concerned by what his patients tell him they think. He is more interested in what they say they did because that is how they got to the state they are in and how they are also going to get out of it. "To change the way a person feels and thinks about himself, we must change the way he acts toward others; and by constantly treating inhibition, we will be constantly getting at the roots of his problem" (Salter, 1949, p. 100).

Salter's state of excitation bears great similarity to the modern concept of assertiveness. There are three basic differences between them. First, Salter advocates excitatory procedures for virtually every conceivable psychological disorder. Therapists using

current assertive training techniques would not assume that every client is primarily in need of assertive training. Second, whereas Salter views assertiveness as a generalized trait, the present conceptualization of assertiveness is that of a situation-specific behavior. That is, assertiveness involves the questions "to what degree?" and "in what situations?" (Mize, 1975, p. 47). Third, Salter showed little concern for the interpersonal consequences, especially negative, of excitatory behavior. Being assertive, by present definition, involves being socially appropriate. Assertive persons take into account the consequences of their behavior and the impact it may have on others.

Assertive training as it is presently conceptualized originated with the work of Joseph Wolpe. Wolpe interprets assertive responses in terms of his theory of reciprocal inhibition as a therapeutic principle: "If a response antagonistic to anxiety can be made to occur in the presence of anxiety-evoking stimuli so that it is accompanied by a complete or partial suppression of the anxiety responses, the bond between these stimuli and the anxiety responses will be weakened" (Wolpe, 1958, p. 71). His basic hypothesis is that assertive responses or behaviors are incompatible with anxiety. In other words, when individuals express themselves assertively, anxiety is reduced and assertive responses are strenghtened.

Wolpe applies the term assertive "to any overt expression of spontaneous and appropriate feelings other than anxiety. Assertive behavior is used to overcome anxiety that is evoked in interpersonal situations and that inhibits appropriate verbal responses together

to other people" (Wolpe, 1976, p. 20). To Wolpe (1958) assertive behavior refers not only to anger expressing behavior, or standing up for one's rights, but also to the outward expression of friendly, affectionate and other typically nonanxious feelings. "The contexts in which assertive behavior is an appropriate therapeutic instrument are numerous. In almost all of them we find the patient inhibited from the performance of 'normal' behavior because of neurotic fear. He is inhibited from saying or doing things that seem reasonable and right to an observer. He may be unable to complain about poor services in a restaurant because he is afraid of hurting the feelings of the waiter; unable to express differences of opinions with his friends because he fears they will not like him ... and unable to express affection, admiration or praise because he finds such expression embarrassing" (Wolpe, 1973, p. 81). Wolpe also points out that "besides the things he cannot do because of fear, there may be others he cannot stop doing. For example, he may compulsively reach for the lunch check again and again to ward off a fear of incurring an obligation" (Wolpe, 1973, p. 81).

Whereas Salter describes nonassertion as a generalized trait, Wolpe defines it as a conditioned response to a specific circumstance or situation. He applies assertive training only in specific contexts which evidenced a need for it. He acknowledges that there are some patients who are nonassertive in a very wide range of interactions and feels Salter's term "the inhibitory personality" is descriptively appropriate to that group. In situations such as these he suggests almost any social interaction might be suitable for assertive training.

The kind of assertive behavior that is most used in therapy is aggressive or anger-expressing behavior (Wolpe, 1958, p. 114). Wolpe assumes that some measure of resentment is present with the feelings of anxiety and helplessness at most times. The anxiety inhibits the expression of the resentment. He further suggests that, since anxiety inhibits the expression of resentment, it might be expected that augmenting the resentment to force its outward expression would reciprocally inhibit the anxiety and thus suppress it to some extent at least. "Each time the patient, by expressing his anger, inhibits his anxiety, he weakens in some measure the anxiety habit" (Wolpe, 1973, p. 85). The role of the therapist is to increase the clients' motivation to express themselves assertively. This, Wolpe suggests, can be accomplished by means of various exhortations, including pointing out to clients the emptiness of their fears and showing them how their fearful modes of behavior have incapacitated them and put them at the mercy of others (Wolpe, 1958, p. 115).

Wolpe advises that the therapist should encourage assertive behavior on the part of the client only when "the anxiety evoked by the other person concerned is maladaptive" (Wolpe, 1958, p. 118). By this statement he means that the client feels anxiety in a situation even when there is no valid reason to do so, when no negative repercussions can reasonably be expected. In situations that call for some action, but in which direct assertion would be inappropriate, Wolpe advocates the use of indirectly aggressive tactics (Wolpe, 1973, p. 90).

Wolpe utilizes a form of behavior rehearsal in his assertive training. In an attempt to prepare the patient to deal with real people in real relationships, the therapist and the patient act out short exchanges in settings from the patient's life. While patients represent themselves, the therapist assumes the role of someone towards whom the patient feels unadaptively anxious and inhibited. In actual fact, a certain amount of deconditioning of anxiety can occur during the behavior rehearsal itself (Wolpe, 1958).

There are two other theorists who have contributed directly or indirectly to the contemporary assertive training process. One is J. L. Moreno, the founder of psychodrama, a method of psychotherapy that involves the use of role playing in order to achieve insight. Assertion training draws from psychodrama its employment of staged dramatizations of the real life attitudes and conflicts of those participating clients. Psychodrama also strongly emphasizes spontaneity and improvisation, both of which Salter stressed. As a role-playing strategy, psychodrama is similar to one of Wolpe's principal assertive techniques, behavior rehearsal, as it is used in assertive training. The goal in psychodrama is for the clients to achieve insight through the acting out of existing relationships, whereas the goal of behavior rehearsal in assertive training is to enhance and expand the client's repertoire of assertive behaviors (Mize, 1975, p. 50).

A second theorist whose contributions are indirectly related to current assertive training practices is G. Kelly who has devised what

he calls "fixed-role therapy" (Kelly, 1955). Fixed-role therapy is based upon Kelly's "personal construct" theory of personality. According to Kelly, people look at the world and the events that happen to them in terms of constructs they have developed from their own individual experiences. Fixed-role therapy involves ascertaining the client's particular constructs as well as determining the constructs the client must have in order to resolve problems. The therapy involves deriving a personality sketch of a fictitious individual who is free of the anxieties and behavioral inadequacies which plague the client. The client is then asked to assume the role of the hypothetical person who possesses the desirable constructs. This includes behaving in a manner consistent with the role as well as adopting the fictitious person's way of looking at or perceiving the world, until clients no longer feel they are assuming roles (Kelly, 1955). The role-playing features are quite similar to the behavior rehearsal techniques used in assertive training. Even though training is not specifically aimed at modifying a client's cognitions, Rimm and Masters (1974) report that case histories suggest that individuals do undergo certain attitudinal changes as a result of treatment, especially in relation to self-perception.

Research on Treatment Procedures and Behaviors Important to Assertiveness

In the therapeutic setting the assertive training procedure is traditionally one of therapist modeling with role-playing interchange between the client and therapist. This essentially encompasses

four components: modeling by the therapist of appropriate assertive behaviors, behavioral rehearsal on the part of the client, feedback to the client from the therapist and reinforcement of the client's assertive attempts (generally by the therapist's verbal expression of approval). The approach taken by many researchers, particularly in the early studies of assertive training, was to compare various treatment procedures as to their effectiveness in increasing assertive behavior.

Lazarus (1971) considers behavior rehearsal to be the primary methodology of assertive training. In 1966 he reported what he claimed to be the first "objective" clinical study of behavior rehearsal. He compared it with direct advice and nondirective therapies in training patients to be more assertive. Behavior rehearsal was shown to be effective in 86% of the cases in which it was used, whereas the other approaches were only 44% and 32% effective, respectively (Lazarus, 1966). For those clients who are very non-assertive, Lazarus advocates the use of behavioral rehearsal in a hierarchical manner similar to that used in systematic desensitization. This methodology, called rehearsal desensitization (Piaget & Lazarus, 1969), involves gradual presentation of anxiety-arousing situations, starting from the least anxiety-provoking and moving to the most anxiety-provoking.

McFall and Marston (1970) cited the lack of systematic research on behavior rehearsal and pointed out several factors which needed to be reckoned with in studying the effectiveness of behavior rehearsal

therapy in assertive training. First, the behavior rehearsal treatment procedure had never been standardized. Second, the behavior rehearsal technique was typically applied to poorly defined and unspecified behavior classes. Third, there were no satisfactory, reliable, objective laboratory and/or real life measures available to assess the behaviors typically treated with behavior rehearsal. What followed was a series of experiments aimed at the evaluation and development of behavior rehearsal therapy.

In the first study of this series McFall and Marston (1970) developed a standardized, semiautomated behavior rehearsal treatment procedure and used it in examining two experimental questions: (1) is simple rehearsal, alone, sufficient to produce significant and desired changes in the problem behavior and (2) what is the therapeutic importance of response feedback -- specifically, feedback via the playback of tape recorded rehearsal responses? Results of behavioral, self-report and psychophysiological laboratory measures, as well as an unobtrusive in-vivo assertive test, revealed that individuals receiving response practice improved significantly more than those in placebotherapy and untreated controls, and that response feedback tended to augment these effects although not to a significant degree.

In a subsequent study McFall and Lillesand (1971) added two new treatment components, symbolic modeling and therapist coaching, to the rehearsal with feedback procedure. They focused on the more limited and homogeneous response class of refusal behavior. Results on a behavioral measure, a self-report measure and an in-vivo follow-up measure supported the conclusion that both symbolic modeling and

therapist coaching made significant contributions to the assertive training procedure.

The rehearsal-modeling group was divided into two parts. One-half of the individuals engaged in overt response rehearsal while the rest engaged in covert rehearsal. Overt response rehearsal occurs externally and allows the therapist to monitor the subject's responses during training. Covert procedures, on the other hand, occur within the imagination (Cautela, 1970). They are more difficult to monitor, but they do offer the advantages of being more flexible, easier to arrange and often less threatening (McFall & Lillesand, 1971). The results of this study indicated that covert rehearsal is at least as effective in refusal training as overt rehearsal, if not more so.

McFall and Twentyman (1973) further assessed the contributions of rehearsal, modeling and coaching to an experimental assertion-training program in four experiments. The training components of rehearsal and coaching both contributed significantly to the subjects' improved performance on self-report and behavioral measures of assertion. They found that the modeling component used in the studies added little or nothing to the training effects of either rehearsal alone or rehearsal plus coaching. This was true regardless of the particular type of models employed (tactful versus abrupt) or the means of presentation (audiovisual or auditory). No differences were found among the three modes of rehearsal examined (covert rehearsal, overt rehearsal or a combination or covert and overt rehearsal). Positive treatment effects generalized from trained to untrained

situations, and in the final experiment there was some evidence that the treatment effects generalized from laboratory to real-life situations.

An even broader study of assertive behavior was that of Friedman (1971) who investigated the effectiveness of modeling, role playing and modeling plus role playing. One hundred five low-assertive male and female college students (low assertive refers to the inability of a person to engage in behavior which indicated he feels entitled to exercise certain rights) were assigned to one of six treatment conditions: modeling (students observed assertive models); directed role playing (students enacted the role of assertive model, following a script); improvised role playing (students were given the same script as those in the directed role playing condition except that their responses were deleted); modeling plus directed role playing; assertive script (students simply read silently to themselves the assertive script employed in the other treatment conditions) and nonassertive script which was designed as a control group. The primary behavioral measure involved taping the students' interactions with a live confederate who became increasingly annoying to them. The students' verbal responses were rated by blind judges on five verbal categories (threat, demand, insult, strong disagreement, request to stop). The total number of responses in all five categories gave a Sum Assertion score. Subjects also filled out a series of personality tests including an Assertiveness test constructed for this experiment composed of short descriptions of ten behavioral situations with five or six alternative reactions to each situation.

The overall effectiveness of these treatment procedures in changing assertive behavior was substantial. The live-modeling treatment elicited between 44% and 63% criterion (assertive) behavior at posttesting. The most promising result was that 69% to 81% of low assertive males and females in the modeling-plus-directed-role-playing condition showed assertive behavior at posttreatment testing which was equivalent to members of an independently assessed high assertive group. Friedman also found that the improvised role-playing condition elicited high levels of assertive behavior at posttesting for 50% of males and females. He makes an interesting point when he claims that his results indicate that students who could improvise responses during a role playing procedure could later transfer these responses to another behavioral situation, and that socially inhibited students who were incapable of thinking up and improvising assertive responses during role playing were unable to profit a great deal from the improvised role playing procedure. He goes even further and says that the improvised role playing was as effective as the directed role playing condition. Consequently, explicit cues to guide training participants' behavior would not seem to be necessary for those individuals who can construct their own assertive responses during a role playing procedure.

Perhaps the most important practical implication of this study is the importance of matching the treatment program to the needs of the particular clients. For nonassertive persons who have no repertoire of assertive responses, it would seem that a treatment

consisting of modeling plus directed role playing or behavior rehearsal would be much better than modeling alone. In instances where individuals have assertive responses in their repertoires but fail to employ them frequently or appropriately, an improvised role-playing technique might be appropriate. In this instance, modeling would probably be extraneous.

Although the above studies contributed significantly to the understanding of assertive training, they failed to specifically enumerate those behaviors which are considered important in assertiveness. While a variety of techniques had been used to increase assertiveness (e.g., behavior rehearsal, audio and/or videotape feedback and modeling) there was little attention directed toward specifying what actual behaviors are altered as a consequence of assertive training. To examine this question Eisler, Miller and Hersen (1973) videotaped psychiatric patients interacting in a series of role-played situations with a live stimulus model. Interactions were then rated on nine behavioral components of assertiveness which had been compiled by researchers. Several experienced clinicians had listed specific behaviors that they felt might be related to acting assertively in negative contexts. They identified nine behaviors and five specific factors capable of differentiating individuals high in assertiveness from those low in assertiveness. There were two verbal indices: compliance content (whether or not the person acquiesced to an unreasonable request) and content requesting new behavior (from the model). And there were three nonverbal indices: loudness of speech, latency of response and affect (emotional tone of voice).

In a later study Hersen, Eisler, Miller, Johnson and Pinkston (1973) demonstrated that different assertive training procedures differentially affected changes in these specific factors. For instance, they found that in modifying a subject's loudness, giving him verbal instructions about what he should do was more effective than modeling alone, whereas in modifying his compliance content modeling was a much more helpful training procedure. This study also confirmed earlier findings by Eisler, Hersen and Miller (1973) that just practicing behaviors without the addition of techniques such as instructions, modeling, or a combination of the two will not lead to behavioral change in terms of the components of assertiveness. Underlying this finding is the assumption that "an individual evidencing a behavioral deficit must be taught a new way of responding as appropriate responses are simply unavailable in his current repertoire" (Hersen, Eisler, Miller, Johnson & Pinkston, 1973). These results are in conflict with earlier findings that rehearsal by itself may result in noticeable improvement on a subsequent behavioral assessment of assertiveness. Rimm, Snyder, Depue, Haanstad and Armstrong (1976) later conducted an investigation which further reinforced the theory that the results of practice alone are negligible.

A more recent study by Eisler, Hersen, Miller and Blanchard (1975) examined the effects of social context on interpersonal behavior in assertive situations. They explored the idea that behaviors which are socially appropriate in one circumstance may not be so in another. Male psychiatric inpatients role played

scenes with nonpatient males and females who took the parts of persons either familiar to the subject or unfamiliar to him. It was presumed that a patient's responses to a person he interacted with on a day-to-day basis would differ from his responses to less familiar persons. At the same time the experimenters sought to identify some of the behavioral components of positive assertion by using some situations that typically elicit positive responses. Results demonstrated significant differences between how patients responded in situations requiring positive or negative assertions. The results also supported a stimulus-specific theory of assertiveness (that is, an individual who is able to be assertive in one interpersonal context may not be in a different situation).

Rathus (1973) hypothesized that college women who observed videotaped models and practiced specific assertive responses would report more assertive behavior and be rated more assertive by judges than women in two control groups. The groups met for one hour sessions once a week for seven weeks. The assertive training group viewed a videotape each week in which assertive models were observed interacting and discussing their assertive experiences. The models demonstrated nine types of assertive responses: assertive talk, feeling talk, greeting talk, disagreeing passively and actively, asking why, talking about oneself, agreeing with compliments, avoiding trying to justify opinions and looking people in the eye. In addition to viewing the tapes, the assertive training group members practiced 20 assertive behaviors each week and kept a record of their

interactions. Results indicated that the training method was significantly effective in inducing assertive behavior. There was also a consistent trend for women receiving this assertive treatment to report lower general fear and fear of social conflicts than did those who received a placebo treatment or no treatment.

Kazdin (1974, 1975, 1976) has investigated the problem of developing assertive behavior with covert modeling from several perspectives. In one of his initial studies (1974) he examined the effectiveness of covert modeling and the influence of favorable consequences following model behavior in increasing an individual's assertive skills. Participants were assigned to one of three treatment conditions: covert modeling (imagined scenes in which a model performed assertively); covert modeling plus reinforcement (imagined scenes in which a model performed assertively and favorable consequence followed model performance), no modeling (imagined scenes with neither an assertive model nor favorable consequences). Control subjects received delayed treatment. Participants in all of the treatment groups, including the no-model condition, showed improvement in self-perceived assertive ability. Only individuals in the model and model-reinforcement treatment groups improved significantly on a role-playing test of assertiveness.

Kazdin (1975) extended this investigation and evaluated the separated and combined effects of multiple models and favorable model consequences in developing assertive behavior. A major purpose of this study was to also assess aspects of the subjects' imagery as

they imagined scenes in the treatment sessions. The participants were assigned to one of three treatment groups: single model/reinforcement (subjects imagined a person similar to themselves in age and of the same sex and favorable consequences followed model performance); single model/no reinforcement; multiple models/reinforcement (subjects imagined a different model/no reinforcement). As they imagined the scene they were instructed to verbalize or narrate it aloud. The scenes were then rated according to whether (1) the scene was complete, (2) the scene had been elaborated upon and (3) the participant had completed the scene in the alloted time. Results indicated that imagining multiple models especially with model reinforcement significantly enhanced the behavioral role playing test. Subjects did adhere to the imagery conditions to which they were assigned, but they tended to elaborate on the scenes periodically. Hence, the actual imagery on the part of the participants may confound the experimental conditions when researching covert modeling.

More recently Kazdin (1976) studied the effects of using a multiplicity of models (imagining a single model versus several models performing assertively) and model reinforcement. The results of this study were unclear. Covert modeling did lead to significant increases in assertive behavior and imagining several models engaging in assertive behavior with favorable consequences did enhance the treatment effects. However, in general, the multiplicity of models seemed to have its best effect on self-report measures while model reinforcement affected the behavioral measures.

Kazdin's studies demonstrate that imagining a person modeling assertion in different situations and imagining a favorable outcome following the model's assertion are effective ways of instigating assertive behavior. Nietzel, Martorano and Melnick (1977) claim that given the typically fragile nature of early assertive attempts, clients should also be trained to deal with the noncompliance or negative consequences which some of their assertions will provoke. They designed a covert modeling, plus reply training, treatment procedure which involved two elements: the visualization of a non-complying response to initial assertion by the model and then visualization of a second assertive counterreply by the model. The reply training condition resulted in significantly greater changes in behavioral assertion than the modeling alone.

When Young, Rimm and Kennedy (1973) assessed the value of verbally reinforcing female college students' repetition of responses which had been modeled for them, they found that although modeling as an individual component of behavior rehearsal was effective in improving assertive performance the addition of verbal reinforcement did not significantly augment the treatment effect.

It can be concluded from these studies that assertiveness is a skill that can be learned through the systematic application of a variety of behavioral techniques. Winship and Kelley (1976) designed a study to see if the acquisition of assertive behavior might be facilitated by yet another strategy -- the use of a specific verbal response model. The model focused upon specific verbal response

components that were taught systematically: (1) an empathy statement (the ability to see the situation through the other person's eyes), (2) a conflict statement (the individual's communicative rationale for action) and (3) an action statement (what it is the individual wants to have happen). Twenty-five undergraduate nursing students were randomly assigned to either an assertive training group, an attention control group and a no-treatment control group. The assertive training group spent four 2-hour group sessions learning and practicing the verbal response model through the use of modeling, behavior rehearsal, videotape feedback and positive reinforcement. All groups were posttested on a self-report scale, on responses to written situations and on a videotaped role playing situation. Significant differences were found between the assertive training group and the other two groups but not between the two control groups themselves. This indicates that training people to use a specific verbal response model can be an effective method for helping them learn how to be more assertive.

As practiced in a clinical setting, assertive training may include a combination of the techniques mentioned above as well as procedures such as bibliotherapy, therapist exhortation and/or reinforcement, group support and didactic exercises. Galassi, Galassi and Litz (1974) designed a methodology to investigate the effectiveness of a total assertive training package. Their study was unique in several ways. First, students were taught to emit a series of assertive responses rather than a single response. They learned a

number of assertive behaviors which included expressing affection, refusing requests and initiating requests, and they were given videotape feedback on their performance in role-playing situations. Experimental subjects received eight training sessions consisting of videotape modeling; behavior rehearsal; video, peer and trainer feedback; bibliotherapy; homework assignments; trainer exhortation and peer group support. The sessions were held twice a week for an hour and a half in three 30-minute segments. During the first part of each session group members discussed the rationale behind self-assertion, readings related to the training and outcomes of their in-vivo behavior practice sessions. Next, the groups looked at videotapes of models involved in assertive interactions. They then divided into dyads and practiced the modeling scenes. Group members who were practicing received feedback from their peers and/or the trainer. The assertive group's performance on self-report and behavioral indices was significantly better than that of the control group. Included were significant differences in three behaviors considered important in assertiveness, namely percentage of eye contact, length of scene and assertive content. A follow-up study a year later (Galassi, Kostka & Galassi, 1974) showed that differences between treatment and control groups were maintained on the self-reports and in eye contact and scene length.

These studies were the first to question the value of using decreased response latency as a variable in assessing assertive behavior. They failed to find significant differences in response

latency between the experimental and control groups as were present in the findings of other investigators (Eisler, Hersen & Miller, 1973; McFall & Lillesand, 1971; McFall & Marston, 1970). Making the point that response latency is determined by many factors other than anxiety aroused by being assertive, such as cultural and geographic differences, the authors (Galassi, Galassi & Litz, 1974) say that in their study it was necessary to train some individuals to increase rather than decrease response latency. These persons were taught not to blurt out ineffectual responses when confronted by another individual but rather to concentrate on producing appropriately assertive statements.

The contribution of videotaped feedback to assertive training was not really assessed by this study. Individuals involved ranked it as numbers one and four in importance among the ten components of the assertive training program as far as helping modify behavior, but there were no tests of significance. McFall and Twentyman (1973) found that audiovisual modeling added little to training in assertiveness, and a number of other researchers have found, contrary to expectations, that videotaped feedback did not contribute to the therapeutic impact of behavior rehearsal (Aiduk & Karoly, 1975; Melnick & Stocker, 1977). Gormally, Hill, Otis and Rainey (1975), evaluating a microtraining approach for training situationally nonassertive clients in assertive expression, found the use of videotape feedback had little effect. Their results indicated that training which includes specific behavioral feedback and rehearsal is a more effective change producer than is insight-oriented counseling

dealing with why the person is not able to be more assertive. The feedback itself seems to be what is important, rather than how the feedback is given. They make the point that using video-tape feedback during the initial stages of training may give the trainee more data than he can use (Gormally et al., 1975). McFall and Marston (1970), on the other hand, have shown that audio-tape feedback was an important component in assertive training.

In contrast to earlier studies (McFall & Marston, 1970; McFall & Lillesand, 1971; McFall & Twentyman, 1973) the Galassi, Kostka and Galassi (1974) follow-up study strongly indicates the long-term effects of assertive training. There are two possible reasons for the discrepancy in these results. The first is that Galassi, Galassi and Litz (1974) used a longer, more intensive and complex treatment program. Particularly significant here is that their treatment program lasted a total of 12 hours (sessions were approximately one and one-half hours and were held twice a week for four weeks). Treatment time in the McFall studies varied from 40 minutes (McFall & Lillesand, 1971) to four hours (McFall & Marston, 1970). The second explanation for the discrepant results might be the follow-up procedure. The follow-up in the Galassi study was conducted in the laboratory whereas the McFall studies relied primarily on in-vivo follow-up (self-report diaries or phone calls). Although in-vivo follow-up has the potential of providing a stronger test of assertion training than laboratory assessment, the procedures used

in the McFall studies might have been confounded by other variables that make results difficult to interpret (Galassi, Kostka & Galassi, 1974).

Another issue relevant to treatment procedures in assertiveness training is the question of whether the training should be carried out individually or in a group. With the exception of a few studies (Rathus, 1973; Galassi, Kostka & Galassi, 1974) all of the above research involved treatment on an individual basis. However, a growing number of clinicians have come to recognize that the various procedures of assertive training can be applied to the treatment of groups as well as individuals. Fensterheim describes the use of assertive training in the context of a group and specifically notes how "the social nature of assertive training suggests that it would be particularly effective in the treatment of groups" (1972, p. 162). He is one of only a few authors who have published a clinical description of such a group. Group treatment also has the advantage of being efficient. Assertive training in groups has been suggested to be an effective vehicle for working with women (Osborn & Harris, 1975), a speculation grounded in research with groups comprised exclusively of women (Gambrill & Richey, 1975; Winship & Kelley, 1976; Rathus, 1973). But there is also evidence pointing to its effectiveness as a treatment procedure in assertive training for men (Rimm, Hill, Brown & Stuart, 1974) and for mixed groups (Galassi, Galassi & Litz, 1974).

This review of the research literature indicates that assertive training is an effective procedure for use with individuals who lack the social and interpersonal skills to ensure successful functioning. Assertive training is specifically directed toward teaching them more effective ways of responding. The evidence also indicates that lack of assertion is rarely a generalizable trait. Deficiencies are generally limited to specific types of situations. For instance, a person who is quite assertive in impersonal situations might be quite the opposite in personal interactions, and the person who voices negative emotions freely may be unable to express positive ones.

The specific treatment procedures used in assertiveness training have been examined and some understanding of the elements necessary for change has been reached. The assertive training procedure can be conceptualized as an active process taking place between the therapist and the patient or the leader and the participant. Their relationship is similar to that between teacher and student: the therapist instructs, models, coaches and reinforces appropriate verbal and nonverbal responses; the client practices newly acquired skills first in a protected environment and then in real life situations (Hersen, Eisler & Miller, 1973).

Applications of Assertive Training

Case Studies on the Applications of Assertive Training

There have been widespread clinical applications of assertion training. The following case studies illustrate how assertive training

has been used either alone or with other treatment strategies for various problems.

Walton (1961) reported a case in which assertive training was used in treating violent somnambulistic behavior of a 35-year-old male against his wife. The patient related his behavior to his poor relationship with his mother, whom he found domineering and authoritarian. The therapist hypothesized that during wakefulness the patient's intense anxiety prevented his solving this problem. In sleep his learned fear responses were reduced, hence his behavior. Treatment consisted of only one interview and involved the development of more assertive behavior by the patient toward his mother. The somnambulistic behavior decreased after two weeks and had been completely dissipated by the time of follow-up two months later. There was neither recurrence nor evidence of symptom substitution.

Cautela (1966) combined (1) reassurances, (2) relaxation, (3) desensitization and (4) assertive training to treat three individuals exhibiting pervasive, free-floating anxiety. He used desensitization and reassurance to inhibit their anxiety and assertive training and relaxation to help them realize they could control their own behavior.

The first case was that of a 23-year-old single female school teacher who was so fearful of other people that her job was in jeopardy. After 33 hours of behavior therapy she had almost a complete remission of symptoms. The second case was that of a 25-year-old

female doctoral student and teacher who reported extreme tension. This client revealed that she was an only child who was completely dominated by her mother whose values were very different from her own. When she disagreed with her mother, the mother would scream, resulting in a panic reaction in the patient. A number of stimuli induced her fear and anxiety: talking about sex, religion and being married; criticism and teasing and any parental disapproval. After 32 sessions she was able to control her fear and anxiety in all real-life situations. The third case concerned a 45-year-old draftsman who came for therapy for his feelings of anxiety. The patient had recently been hospitalized for a bleeding ulcer. While he was hospitalized his wife began working and became quite successful and independent. As she became more independent and dominant the client became more passive, dependent and anxious. This client was desensitized to criticism and began to achieve some success in being assertive. With him, however, a really significant decrease in anxiety was noted only after desensitization about sexual activity with his wife.

Seitz (1971) described the treatment of a neurotically depressed 36-year-old widowed male patient who was hospitalized following a suicide attempt. Here assertive training was used in combination with three other behavior modification techniques. Assertive training was initiated in order to increase appropriate social interaction behaviors. The rationale was that this type of behavior would be incompatible with the depressive, self-defeating behavior exhibited

by the patient. This patient showed improvement after eight weeks of therapy.

Lambley (1976) treated a 38-year-old woman suffering from migraine headaches with a combination of assertive training and psychodynamic insight. Lambley makes the point that since migraine is essentially a psychosomatic condition, and as such, involves the functioning of both somatic and psychological systems, treatment methods must be multidimensional including both behavioral and psychodynamic insight techniques.

This woman's case history data revealed several areas of possible psychodynamic conflict with specific people such as her husband and her mother and behavioral analysis indicated that she was unable to assert herself in day-to-day interactions and tended to avoid any situations which might cause friction. Assertive training was employed to teach the woman what to do if conflict occurred and psychodynamic insight into the reasons for the conflict to perhaps keep it from occurring altogether.

Foy, Eisler and Pinkston (1975) reported the case of a 56-year-old male who was successfully trained to control chronic abusive and assaultive behavior by use of modeling alone and modeling combined with instructions focused on desirable features of the modeled behavior. A six month follow-up showed that changes in behavior had been maintained and had generalized to the natural environment. Eisler, Hersen and Miller (1974) reported the modification of periodic rages in a 28-year-old man who had difficulty expressing anger in interpersonal situations.

The main emphasis in these cases has been on the interpersonal consequences of a lack of appropriate assertive behavior or on the somatic symptoms that have been considered side effects associated with unexpressed impulses. Rimm (1967) examined another response which sometimes occurs in response to the inhibition of anger-crying. The case he worked with involved a 38-year-old man who cried excessively in response to situations which made him angry. Rimm made the point that excessive crying is inappropriate behavior for males. However, this concept of crying as dysfunctional behavior in handling anger can also be extended to women. To break the cycle involving anger and crying, assertive training was initiated. To teach the patient to be assertive rather than fearful in the face of anger-inducing stimuli, a shock escape technique was employed, an unusual procedure in the assertive training literature. Improvement was noted after two months of therapy.

These case studies illustrate the versatility of assertive training as a therapeutic tool. Although treatment methods are presented, the precise evaluation of particular techniques is unavailable in most cases. Except for Foy et al. (1975) and Eisler et al. (1974) the case studies mentioned above offer only global clinical judgments of improvements.

Research Studies on the Applications of Assertive Training

Behavior therapy research has generally focused on demonstrating that behavior can be changed. The widespread attention of researchers in the area of assertive training to treatment procedures which will enhance subjects' assertive skills reflects this focus.

Changing an individual's behavior, however, would seem to be of little consequence if the person still feels anxious, unhappy, upset and/or worthless. It seems necessary to also assess the cognitive and attitudinal changes which accompany changes in the individual's behavior (Percell et al., 1974). The following studies attend to this need and can be divided into two categories: those which correlate assertiveness with other variables and those which have a training component to show whether becoming more assertive can, in fact, change other variables.

Research has indicated that the assertive individual is expressive, spontaneous, well defended, confident and able to influence and lead others while the nonassertive person more often feels inadequate and inferior, has a marked tendency to be oversolicitous of emotional support from others and exhibits excessive interpersonal anxiety (Galassi, De Lo, Galassi & Bastien, 1974). It would seem, then, that there is an association between assertiveness and such variables as locus of control, self-confidence, self-concept, personal adjustment and anxiety. There is some research available which supports this assumption.

The concept of locus of control refers to the extent to which individuals view rewards as contingent on their own behavior. When a reinforcement is perceived by individuals as contingent on their own behavior, Rotter (1966) terms this a belief in internal control. When individuals see events as independent of their own actions, as a result of luck or chance, then he terms it a belief in external control.

Bates and Zimmerman (1971) have directly investigated the relationship between assertiveness and locus of control. Significant results were obtained from individuals taking the Rotter I-E Scale, a measure of generalized expectancy for internal versus external locus of control, to test the notion that nonassertive subjects are more likely than assertive subjects to perceive reinforcements as externally controlled. It follows that nonassertive individuals can be considered more compliant to external demands than their more assertive peers. Appelbaum, Tuma and Johnson (1975) substantiated that internals are significantly more assertive than externals. Rimm et al. (1974) tested a small group of subjects participating in assertion training to modify antisocial aggression to see if they became more assertive or changed their locus of control. The found no significant differences between treatment and control groups on either assertiveness or locus of control, findings which conflict with those of other researchers. The findings are in line, however, with Gay, Hollandsworth and Galassi's (1975) findings that locus of control did not discriminate between low- and high-assertive subjects.

A number of theoreticians in the area of assertiveness have speculated that there is a relationship between peoples' level of assertiveness and their feelings of self-confidence (Salter, 1961; Wolpe, 1958; Alberti & Emmons, 1974). Gay et al. (1975) found that subjects scoring high on their Adult Self-Expression Scale (ASES)

described themselves as more self-confident than low scorers. Correlational data for the ASES with the Adjective Check List need scales indicated that high scorers are more achievement oriented, more likely to seek leadership roles in groups and individual relationships, more independent, less likely to express feelings of inferiority through self-deprecation and less deferential in relationships with others. These findings are very similar to the findings of both Bates and Zimmerman (1971) and Galassi, DeLo, Galassi and Bastien (1974).

Percell et al. (1974) also found a significant positive correlation between assertiveness and self-concept when they administered a battery of tests including the Lawrence Interpersonal Behavior Test (for assertion) and the Self-Acceptance Scale of the California Psychological Inventory to a group of outpatient psychiatric patients. Later, in an experiment to assess the effects of assertive training on the same population, they found that as individuals became more assertive they also became more self-accepting (Percell et al., 1974).

Another variable that seems to relate to assertiveness is personal adjustment. Galassi and Galassi (1974) found that students who sought personal adjustment counseling were significantly less assertive than both noncounselees and students who sought only vocational-educational counseling. Gay et al. (1975) reinforced this when their study of an assertiveness inventory for adults revealed that individuals seeking personal adjustment counseling scored significantly lower on the Adult Self-Expression Scale (ASES) than adults in general. Bates and Zimmerman (1971) related scores on their Constriction Scale to scores

on the Adjective Check List Counseling Readiness Scale (these scores are thought to reflect self-dissatisfaction). The data suggested that constricted males are less tolerant of their own lack of assertiveness in comparison to constricted females for whom a demure, passive sex role alternative is sanctioned by society.

The variable which has received the most attention regarding its relationship to assertive behavior is anxiety. Behavior therapists have long speculated about the relationship between social fears or social anxieties and lack of assertive behavior. The association between them has been supported by a number of investigations.

Morgan (1974) administered the Wolpe-Lang Fear Survey Schedule and the Rathus Assertivenss Schedule to psychology students and found a small but statistically significant relationship between assertiveness and social fear.

Bates and Zimmerman (1971) administered the Constriction Scale and the Multiple Affect Adjective Check List to 600 students as one of the validation procedures for the Constriction Scale. They found a significant correlation between scores on the two scales which affirmed their hypothesis that anxiety is positively correlated with being nonassertive.

Galassi, De Lo, Galassi and Bastien (1974) found that college students scoring low on a measure of assertiveness selected adjectives on a checklist that indicated excessive interpersonal anxiety. Students who scored high, on the other hand, were confident.

Gay et al. (1975), using 464 subjects ranging in age from 18 to 60 years, administered the Adult Self-Expression Scale and the Taylor's Manifest Anxiety Scale as one of the validation studies for ASES. They found that the measure of anxiety clearly differentiated low from high assertives as identified by the ASES.

Percell et al. (1974) hypothesized that there would be significant negative correlation between measures of assertiveness and anxiety. The hypothesis was supported in a study with 100 psychiatric patients. Orenstein, Orenstein and Carr (1975) found the same using 450 college students.

Besides these correlational studies there have been several assessments of the effectiveness of assertiveness training in eliminating or reducing anxiety. Rathus (1973) administered both an assertiveness inventory and a fear survey to groups of female students receiving either assertive training, a placebo treatment or no treatment. The group receiving the assertive training did not become significantly more assertive and, though results were not significant, did show greater reduction of fear than did the groups not receiving assertive training.

Rimm, Hill, Brown and Stuart (1974) reported that male student volunteers reporting a history of expressing anger in an inappropriate or antisocial manner reported significantly greater decreases in feelings of "uptightness" after receiving eight hours of assertive training than did controls.

Percell et al. (1974) tested the hypothesis that outpatient psychiatric patients would exhibit a decrease in anxiety after receiving assertive training. The Lawrence Interpersonal Behavior Test (a test of assertion) and the Taylor Manifest Anxiety Scale were administered to a group of seven male and five female outpatient psychiatric patients, before and after eight sessions of group assertive training, and to a group of five male and seven female outpatient psychiatric patients before and after eight sessions of a relationship-control therapy group. Both groups had essentially the same format, discussing the advantages of being assertive, exploring the situational determinants of each subject's nonassertive behavior and giving advice on how to behave more effectively and solve some of their problems. The assertive training group incorporated behavior rehearsal. The results of the study supported the hypothesis that anxiety would decrease as the patients became more assertive.

Gambrill and Richey (1975) have developed the Assertion Inventory which permits respondents to note for each item their degree of discomfort as well as their probability of engaging in the behavior. Normative data from a sample of 19 women participating in assertion training programs showed a significant reduction in mean discomfort scores after assertion training.

There appears to be a definite relationship between assertiveness and locus of control, self-confidence, self-concept, personal adjustment and anxiety. Another interesting finding in the research literature deals with the relationship between assertiveness and

aggressiveness. Galassi, De Lo, Galassi and Bastien (1974) found a nonsignificant correlation between aggression, as measured by the Adjective Check List and scores on their College Self-Expression Scale. This is especially important in view of how aggressiveness is often mistaken for assertiveness. Results of assertive training with individuals who tended to exhibit antisocial aggression (as opposed to temerity) in certain critical social situations (Rimm et al., 1974), although not significant, did suggest that assertive training may provide an effective means for dealing with anger which could lead to antisocial aggression if left unresolved.

Assertive Training for Women

Recently a number of writers have proposed that nonassertiveness is a pervasive cultural phenomenon among women (Jakubowski-Spector, 1973; Lange & Jakubowski, 1976; Osborn & Harris, 1975; Bloom, Coburn & Pearlman, 1975). They talk about women as "victims" of socialization, stereotyping and institutional sexism which combine to inhibit the fulfillment of their interpersonal rights. Women are conditioned to be passive and nonassertive, so even when new opportunities and choices have become available old feminine conditioning often persists and women find themselves unequipped to cope with them. Persons around them, often hampered by the same stereotypical thinking, frequently fail to offer much needed support. The women's movement has been responsive to this disparity facing many women and has emphasized finding ways to help women learn to express themselves and to experiment with different role behaviors in new

situations. This emphasis has kindled a burgeoning interest in assertiveness training for women.

Assertive training is considered a skill-building process as much as a therapeutic procedure. Hartsook, Olch and de Wolf (1976) have studied the personality characteristics of women who seek assertiveness training and found that these women are "overly concerned with the approval of others and moderately inhibited in expressing their feelings, but in most respects are integrated and autonomous" (Hartsook et al., 1976, p. 326).

The assertiveness training procedure has been used successfully to teach women assertive skills (Rathus, 1973) and has the potential to help them become more effective and fulfilled. Much of the information we have about women and the effectiveness of assertive training is ancillary to research conducted with males and females about treatment strategies in assertive training. We know, for example, that assertive training results were significantly improved for both men and women with the addition of behavior rehearsal (McFall & Marston, 1970), modeling and role playing (Friedman, 1971; Kazdin, 1974) and coaching (McFall & Lillesand, 1971). We also know some things about treatment results; for instance Percell et al. (1974) found that both male and female psychiatric patients improved in anxiety and self-concept as a result of an assertive training program.

Except for the study by Percell et al. (1974) all the projects involved treatment on an individual basis. Several theorists have suggested that assertive training for women is most effective when

conducted in groups (Lange & Jakubowski, 1976; Osborn & Harris, 1975). There is some research available which supports the idea that assertiveness training is effectively carried out in groups with women (Rathus, 1973: Gambrill & Richey, 1975; Winship & Kelley, 1976; Pearlman & Mayo, 1977), but not that it is necessarily better than assertiveness training conducted individually, nor that it is more effective with all-women groups than mixed-sex groups.

Pearlman and Mayo's (1977) data from a follow-up survey indicated that 65% of women participating in group assertiveness training felt their assertive skills increased moderately or greatly in the six to eighteen months after their training had finished. Hartsook et al. (1976) asked for verbal appraisal of their training experience from members of an all-female assertiveness group. Remarks suggested that assertive behaviors had generalized beyond the situations practiced in the group and that group members' interpersonal relations with significant others had undergone radical changes for the better. These findings suggest that women who have participated in assertive training are able to expand their use of the skills beyond their group participation and generalize their assertive behaviors to real-life situations.

Summary

The preceding review of the research literature suggests that assertive training can be an effective treatment procedure for patients who evidence moderate to severe interpersonal behavioral

deficits. With patients who simply do not evidence the requisite social and interpersonal skills to ensure successful functioning, assertive training is specifically directed toward teaching new modes of responding.

Frequently the lack of these interpersonal skills can precipitate a state of anxiety for an individual. This anxiety often manifests itself symptomatically. As patients become more skilled in routine interpersonal interactions, the probability of their receiving reinforcement from their social mileau is increased. At that point symptomatic behaviors become nonfunctional and are eliminated from their repertoires (Hersen, Eisler & Miller, 1973).

The specific techniques contributing to the overall success of assertive training have been examined. Although a full understanding of all the elements producing change has not been achieved, some definite patterns have emerged. Most striking is the extent to which an active process takes place between the therapist and the patient. The relationship approximates that of teacher and student. The therapist instructs, models, coaches and reinforces appropriate verbal and nonverbal responses. Concurrently, the clients first practice their newly developed repertoires in the consulting room and then in actual situations requiring assertive responses (Hersen et al., 1973).

The purpose of the present study was to determine whether an assertive training program using well-defined research procedures can effectively reduce anxiety in a population of women who

exhibit symptoms of that anxiety. Although there has been some research examining the relationship between assertive behavior and anxiety, it has been carried out with small groups of either psychiatric patients or college students and has not considered the element of symptomization.

CHAPTER III

METHODS AND PROCEDURES

Many women evidence moderate to severe interpersonal behavioral deficits. Frequently the lack of these interpersonal skills precipitates a state of anxiety which in turn manifests itself symptomatically. Accordingly there is a need for methods to help women become more effective interpersonally. Assertiveness training has been used successfully to teach women assertive skills and has the potential to help them become more interpersonally effective and fulfilled. This study examined the effectiveness of assertive training in reducing anxiety in a group of women who experience symptomatic manifestations of that anxiety.

Chapter III deals with the hypotheses, population, sampling procedures, instrumentation, treatment proceduresand experimental design used in this study. It also includes an explanation of how the data were collected and analyzed.

Selection of Subjects

Physician Group

Although it is generally considered a psychological phenomenon, many individuals first manifest anxiety in a somatic manner. The somatic complaint, a headache or gastro-intestinal upset, or other

symptoms may, in fact, be the only distress the person feels. Thus, the primary-care physician is often the first professional approached by the anxious patient and is generally the person who initiates treatment.

Primary care is defined as basic or first-contact care. Provision of primary care is the function of the family practitioner, internist, pediatrician or gynecologist. This particular study dealt with adult women who approach their primary-care physician with symptoms of anxiety. The physician sample was drawn from those primary-care physicians who have adult women as patients, namely family practitioners, internists or gynecologists.

This physician group included all residents in the Family Practice Residency Program at the University of Florida College of Medicine as of December, 1977 and those family practitioners, gynecologists and internists listed in the Gainesville, Florida, telephone directory who were practicing in Gainesville during January, 1978. This generated a list of approximately 20 family practice residents, 20 family practitioners, 21 internists and 14 gynecologists. Three of the physicians were women.

Subject Sample

This sample was composed of 82 female volunteers between the ages of 20 and 65 whose primary-care physician had suggested that they might benefit from participation in an assertion training group. They were women who, in the physician's estimation, were experiencing one or more of the following symptoms as a consequence of anxiety: somatic complaints such as headaches, gastro-intestinal distress, dizziness

and muscle soreness; indications of interpersonal sensitivity such as temper outbursts, feelings of inferiority, and feeling critical of others; indications of depression such as a loss of sexual interest or pleasure, poor appetite, crying easily or worrying and stewing about things; indications of anxiety such as feeling fearful, nervousness or shakiness inside, heart pounding or racing or feeling tense or keyed up.

Sampling Procedures

In order to obtain subjects a letter (Appendix A) was mailed to the Family Practice Residency Program at the University of Florida College of Medicine and those family practitioners, gynecologists and internists listed in the Gainesville, Florida, telephone directory who were practicing in Gainesville at the time of the study. This letter explained the nature of this research project and asked the physicians to refer female patients who met the criteria. The researcher followed this letter with a phone call to each physician asking if he would like more information about the project. An appointment was made with the doctors who requested it.

The physicians were asked to refer adult women, defined as women between the ages of 20 and 65, experiencing one or more of the following symptoms: somatic complaints such as soreness of muscles, headaches, gastro-intestinal distress, pain in the heart or chest; trouble getting their breath and faintness or dizziness; indications of interpersonal sensitivity such as feeling critical of others, feeling easily annoyed or irritated, temper outbursts and feelings of

inferiority; indications of depression such as loss of sexual interest or pleasure, poor appetite, crying easily, feeling blue and worrying or stewing about things; and/or indications of anxiety such as feeling fearful, nervousness or shakiness inside, heart pounding or racing and feeling tense or keyed up. The physicians referred women they considered to be experiencing these symptoms as a consequence of anxiety. No patient with evidence of organicity, psychosis, addictive disorder or sociopathy was included. The physicians were asked to tell their eligible patients only that they felt the patient might benefit from participation in the training program.

Enclosed with this letter to the physician were a copy of the researcher's vita (Appendix B) and several copies of a letter from the researcher to the individual patient (Appendix C). Attached to this "patient's letter" was a postage-paid card (Appendix D) which provided space for the women to either express an interest in the training and list times they would be available, or to request further information. The physicians were asked to give a card to each woman as they discussed the program with them.

The letter to the patient explained that a program was being offered to help women feel better about themselves. It also indicated that there was no charge for the program. The letter explained that it was very important to the research part of the project that those women who began the training complete it. Women who were interested were asked to fill out the postage-paid card and return it.

The women were asked to check the following responses on the card before returning it:

_____ Please call as I need more information.

_____ Yes, I want to participate and have indicated at least three (3) times I will be available.

The time periods listed are 10:00 AM - 12:00 PM, 1:00 - 3:00 PM, 3:00 - 5:00 PM and 7:00 - 9:00 PM on Monday through Saturday. The group sessions were held during those time periods most frequently requested.

All women who returned the card were telephoned by the researcher immediately upon receipt of the card. The researcher tried to determine whether a potential subject would be able to attend all seven sessions. The names of interested women were held until a pool of 12 to 16 was attained. The women were then assigned to either a treatment or control group. The treatment group compositions were established according to times each subject indicated as convenient. The subject recruitment process described above was continued until a subject pool of 82 women was reached. Women in the experimental groups began to receive the training as soon as possible. Members of the control groups were offered the training after the posttesting.

Assessment Measures

Participants were asked to complete a personal data sheet (Appendix E) and three self-report instruments: the Adult Self-Expression Scale (ASES), a measure of assertiveness; the State-Trait Anxiety Inventory (STAI) and the Hopkins Symptom Checklist (HSCL), a clinical rating scale which reflects the psychological symptom configurations commonly

observed among medical outpatients. Administration of all of the instruments took approximately one hour. This occurred during the hour immediately preceeding the first treatment session and the hour after the last treatment session. During the last testing session the experimental groups were also asked to fill out a short questionnaire evaluating their experiences during the training (Appendix F).

Descriptions of the assessment measures follows.

The Adult Self-Expression Scale (ASES)

The Adult Self-Expression Scale (Gay, 1974) is a 48 item self-report measure of assertiveness designed for general use with adults. Its construction was based upon a two-dimensional model of assertiveness. One dimension specified interpersonal situations in which assertive behavior might occur, such as interactions with family, the public, authority figures and friends. A second dimension specified assertive behaviors that might occur in these interpersonal situations. The behaviors included expressing personal opinions, refusing unreasonable requests, taking the initiative in conversations and in dealing with others, expressing positive feelings, standing up for legitimate rights, expressing negative feelings and asking favors of others. Both situation-specific and generalized components of behavior were taken into account in the design.

A factor analysis procedure resulted in 14 factors that accounted for 55.91% of the variance. Forty-five of the 48 items on the ASES obtained factor loadings of .40 or greater. Four of the 14 factors were defined in terms of the interpersonal situations in which assertiveness occurs (mentioned above). The remaining 10 factors were

defined in terms of types of assertive behavior (also mentioned above). Three types of assertive behavior were represented by two factors each: expressing positive feelings, standing up for one's legitimate rights, and taking the initiative in one's dealings with others.

The ASES uses a five-point Likert format (0-4). Respondents are asked to answer the questions by indicating how they generally express themselves in a variety of situations. They indicate either "almost always" or "always" (0), "usually" (1), "sometimes" (2), "seldom" (3), or "never" or "rarely" (4). The instructions tell the respondents that if a particular situation does not apply to them they should answer as they think they would respond in that situation. They are told their answers should not reflect how they feel they ought to act or how they would like to act but rather how they generally do act. It takes about 15 minutes to complete the ASES.

A total score for the ASES can range from 0 to 192. There are 25 positively worded and 23 negatively worded items. The 23 negatively worded items must be reverse scored prior to calculating the total score. The mean ASES total score obtained from 640 adults ranging in age from 18 to 60 was approximately 115 with a standard deviation of approximately 20. This would mean that ASES scores falling above 135 are considered high scores while those falling below 95 could be considered low scores.

Test-retest reliability for the ASES was established by administering the instrument to two samples of subjects. Both samples received the initial test administration at the same time. The ASES

was administered a second time to one sample at the end of a two-week period, to the second sample at the end of a five-week period. A Pearson-product moment correlation was computed establishing two and five week reliability coefficients of .88 and .91, respectively. Internal consistency was determined by correlating the total odd scores with the total even scores for 464 subjects using a Pearson-product moment correlation. The results (.79) indicated that the ASES possesses moderate homogeneity. A Spearman Brown r of .88 was obtained for the full test (Gay, 1974; Gay et al., 1975).

Gay (1974) conducted several studies to establish validity data for the ASES. Construct validity was established by correlating the total scores of individuals taking the ASES with their scores on the 24 scales of the Adjective Check List. The ASES was found to correlate positively at the $p < .001$ level with the Number of Adjectives Checked and the Self-Confidence, Ability, Achievement, Dominance, Affiliation, Heterosexuality, Exhibition, Autonomy, Aggression and Change Scales of the Adjective Check List. The ASES was found to correlate negatively at the $p < .001$ level with the Succorance, Abasement and Deference scales of the Adjective Check List.

Concurrent validity for the ASES was established through the method of contrasted groups. Thirty-two clients seeking personal adjustment counseling scored significantly lower ($\bar{X}$ = 101.81) on the ASES than did noncounseled subjects ($\bar{X}$ = 114.20).

Discriminant validity was established for the ASES by examining the relationship between assertiveness and anxiety (as measured by

the Taylor Manifest Anxiety Scale), self-confidence (as measured by the Self-Confidence Scale of the Adjective Check List) and locus of control (as measured by Rotter's measure of generalized expectancy for internal versus external control of reinforcement). A discriminate analysis procedure was performed. It resulted in a significant F value, $F(3,54) = 9.56$, $p < .001$. The univariate tests for the three variables revealed that anxiety $F(1,56) = 17.86$, $p < .001$ and self-confidence $F(1,56) = 20.51$, $p < .001$ did significantly discriminate between low and high assertive groups. Locus of control $F(1,56) = 1.14$, $p < .291$ did not.

Hopkins Symptom Checklist (HSCL)

The Hopkins Symptom Checklist (initially developed by Parloff, Kelmar & Frank, 1954) is a multidimensional symptom self-report inventory. It is comprised of 58 items which are representative of the symptom configurations commonly observed among medical outpatients. It is scored on five underlying symptom dimensions: somatization, obsessive-compulsive, interpersonal sensitivity, anxiety and depression.

The basic symptom constructs underlying the HSCL have been determined through clinical-rational clustering and factor analytic studies. In clustering studies (Lipman, Covi, Rickels, Uhlenhuth & Lazar, 1968) researchers asked highly experienced clinicians to assign the symptoms of the HSCL to homogeneous clinical clusters based on their clinical experience. Symptoms that were assigned with a high level of consistency were returned and provided HSCL cluster definitions. Results of the two studies produced four configurally similar clusters labeled anxiety, depression, anger-hostility and obsessive-compulsive phobic. The HSCL clusters have been used often as criterion measures of improvement, and have been shown to be highly sensitive to change in numerous clinical traits (Lipman et al., 1968).

Williams and her associates (Williams, Lipman, Rickels, Covi, Uhlenhuth & Mattsson, 1968) performed a factor analysis of self-ratings of a large sample of 1,115 anxious neurotic patients. Lipman et al. (1969) factor analyzed psychiatrists' HSCL ratings of 837 of the same patients. In both of these studies five clinically meaningful dimensions were isolated: somatization, fear-anxiety, general neurotic feelings, depression and cognitive performance difficulty.

Another important issue dealt with in the factorial development of the HSCL is the question of factorial invariance or dimensional constancy. This question has to do with the generalizability of the dimensions developed from a specific sample to other samples. Derogatis, Lipman, Covi and Rickels (1971) employed five symptom dimensions (somatization, obsessive-compulsive, irascibility, anxiety and depression) in a study of the factorial invariance of the HSCL. They derived these dimensions by factor-analyzing the HSCL self-ratings of 1,066 anxious neurotic outpatients and psychiatrists' ratings for a subsample of 837 patients. The patients were assigned to one of three social class groups in terms of Hollingshead Two-Factor Index of Social Position. The congruency coefficient and the coefficient of invariance (riv) were used to evaluate the contrasts. Each indicated a high level of invariance for the HSCL symptom dimensions both among patients and between patients and psychiatrists. On the Somatization dimension riv's were above .95 for all three psychiatrist-patient contrasts while the average for the among-patient comparison was .87. Psychiatrist-patient contrasts on the Obsessive-Compulsive factor ranged from .81 to .92 with an average among-patient comparison of .75. On the Anxiety dimension the average of the psychiatrists'

comparisons was .76 while that among patients was .60. The dimension of General Neurotic Feelings exhibited moderate to high similarity coefficients across the three patient groups. The coefficients ranged from .74 between the upper-middle class and lower-class patients to .48 for the working class versus lower class contrast. The comparisons of this factor with the psychiatrists' dimensions resulted in almost equivalent coefficients. Analysis of the Irascibility factor showed riv's of .64 and .67 between the upper-middle class and the working-class groups, respectively, and the psychiatrist's ratings.

Derogatis, Lipman, Covi and Rickels (1972) factor-analyzed the HSCL self-ratings of two patient samples - 641 anxious patients and 251 depressed neuortics. Five symptom dimensions were established (Somatization, Depressive, Obsessive-Compulsive, Anxiety and Interpersonal Sensitivity). They then examined these symptom dimensions regarding dimensional constancy across the categories of anxiety states and depressive neuroses. The Somatization and Obsessive-Compulsive constructs proved to be highly invariant across diagnostic class. They had similarity coefficients of .97 and .96, respectively. The dimension of Interpersonal Sensitivity also reflected high agreement between the two samples (riv = 0.81). The Depression dimension showed considerable invariance (riv = 0.53) yet at the same time reflected overtones unique to each of the diagnostic classes. The Anxiety dimension was not significant because of a failure to sustain a distinct dimensional representation of anxiety for the depressed neurotics. However, the coefficients were of moderate magnitude and in the appropriate direction.

The symptoms that are fundamental to interpersonal sensitivity focus on feelings of personal inadequacy and inferiority, particularly in comparison with other individuals. Self-deprecation, feelings of uneasiness and marked discomfort during interpersonal interactions are characteristic of persons with high scores on this dimension. Other typical sources of distress are feelings of acute self-consciousness and negative expectancies regarding interpersonal communication. There are seven items which make up this dimension. Possible scores range from 7 to 28.

The scales subsumed under the dimension of depression reflect a broad range of the concomitants of the clinical depressive syndrome. Symptoms of dysphoric affect and mood are represented, as are signs of withdrawal of interest in activities, lack of motivation, and loss of energy. This dimension also includes feelings of hopelessness and futility. Eleven items comprise this factor. Possible scores range from 11 to 44.

The anxiety dimension is comprised of a set of symptoms and behaviors generally associated clinically with high manifest anxiety. This dimension includes general indicators such as restlessness, nervousness and tension, as well as additional somatic signs e.g., "trembling." Items touching on free-floating anxiety and panic attacks are also included. This dimension is comprised of 6 items. Possible scores range from 6 to 24.

Fourteen items from the scale are not included in any dimension. This study will be concerned with the dimensions of somatization, interpersonal sensitivity, depression and anxiety as well as a total score or index of symptom distress.

The HSCL is scored on the basis of the five symptom clusters: somatization, obsessive-compulsive, interpersonal sensitivity, depression and anxiety. Patients are instructed to rate themselves on each symptom using a four-point scale of distress as follows: 1 = "not-at-all," 2 = "a little bit," 3 = "quite a bit," 4 = "extremely." Therefore, scores on the rating scale reflect not only the existence of a symptom, but also the extent of the symptom. A description of each of the symptom dimensions follows.

The items comprising the dimension somatization reflect distress arising from perceptions of bodily dysfunction. They include complaints focused on cardiovascular, gastrointestinal, respiratory and other systems with strong autonomic mediation. Headaches, backaches, pain and discomfort localized in the gross musculature and other somatic equivalents of anxiety are also represented. Twelve items contribute to this dimension. Possible scores range from 12 to 48.

The items that form the dimension obsessive-compulsive reflect symptoms that are closely identified with the clinical syndrome of this name. The focus of this measure is on thoughts, impulses and actions that are experienced by the individual as irresistable and unremitting. They are,at the same time,of an ego-alien or unwanted nature. Behaviors indicative of a more general cognitive difficulty (e.g. mind going blank, trouble remembering) also load on this dimension. Eight items comprise this dimension. Possible scores range from 8 to 32.

The HSCL has a flexible time context which means that different temporal limits may be used. Under standard conditions, however, the time context used is seven days. Respondents are asked to respond in terms of "How have you felt during the past seven days including today?"

Two of the major normative samples for the HSCL have been developed around neurotic disorders with primary symptom manifestations of anxiety and depression. A third normative sample is composed of individuals who were administered the HSCL as part of a more extensive health survey. This group represents a complete random sample and contains a high proportion of normals.

There have been a number of reliability studies included in the research on the HSCL. Reliability estimates of the internal consistency of the HSCL symptom dimensions are uniformly high. Alpha coefficients based on an N of 1435 range from .84 to .87. Item-total correlations were also calculated for the items which contributed substantially to each dimension. All of these coefficients were above .50, and most were at about .70. Test-retest coefficients are also available. Based on a sample of 425 anxious neurotic outpatients, they ranged from .75 for anxiety to .84 for the obsessive-compulsive dimension. The patients involved were all participants in a psychotropic drug trial with antianxiety agents. The test-retest evaluations were performed one week apart, prior to the initiation of treatment with medication.

An indication of the construct validity of the HSCL has been provided by Rickels, Lipman, Garcia and Fisher (1972). This study showed that the rank ordering of patient groups according to their

distress levels on the HSCL was identical to the rank ordering suggested by clinical practitioners and independent external criteria. The high internal consistency of the various symptom dimensions also contributes to their validity.

Another study indicates even more extensive validity for the HSCL. Rickels, Lipman, Garcia and Fisher (1972) contrasted HSCL distress levels observed at initial visit in two groups of gynecological normal patients (N=135). Gynecological patients were classed by their treatment physicians as either emotionally labile, i.e., mildly tense or anxious, or nonlabile. Neurotic patients were categorized as unimproved, mildly improved or markedly improved. Results of this study were highly consistent. They showed that the rank ordering of the groups on all five HSCL dimensions proceeded from gynecological nonlabile at the lowest distress levels to unimproved neurotics at the highest. Differences between the groups were statistically significant on all of the HSCL dimensions.

The State-Trait Anxiety Inventory (STAI) Form X

The State-Trait Anxiety Inventory is comprised of separate self-report scales for measuring two distinct anxiety concepts: state anxiety (A-State) and trait anxiety (A-Trait). The theoretical bases underlying the construction of the STAI, as outlined by Spielberger (1966) are as follows: "State anxiety (A-State) is conceptualized as a transitory emotional state or condition of the human organism that is characterized by subjective, consciously perceived feelings of tension and apprehension" (Spielberger, Gorsuch & Lushene, 1970,

p. 3). Since A-States may fluctuate over time and vary in intensity, a measure of state anxiety must be sensitive to stress situations. Trait anxiety (A-Trait), on the other hand, "refers to relatively stable individual differences in anxiety proneness, that is, to differences between people in the tendency to respond to situation perceived as threatening with elevations in A-State intensity" (Spielberger et al., 1970, p. 3). A measure of trait anxiety should be stable and consistent. For a given group of respondents trait scores ought to be correlated with an increase in state scores under stress (Levitt, 1967).

The STAI A-Trait Scale consists of 20 statements that ask people to describe, how they "generally" feel. The A-State scale also consists of 20 statements, but the instructions require respondents to indicate how they feel "at a particular moment in time." The scales are printed on opposite sides of a single test form. This study will make use of both scales.

The range of possible scores for Form X of the STAI varies from a minimum of 20 to a maximum of 80 on both the A-State and A-Trait subscales. Subjects repond to each STAI item by rating themselves on a four-point scale: (1) not-at-all; (2) somewhat; (3) moderately so, (4) very much. The categories for the A-Trait Scale are: (1) almost never; (2) sometimes; (3) often; and (4) almost always. The A-State scale is balanced for an acquiescence set, with ten directly scored and ten reversed items. The A-Trait Scale has seven reversed items and 13 which are scored directly.

The STAI was designed to be self-administering and may be given either individually or in groups. Complete instructions for both scales are printed on the test form. The inventory has no time limit. It generally requires about 15 minutes to complete both scales, depending upon the educational level and/or level of disturbance of the respondents.

The title printed on the test form is SELF-EVALUATION QUESTIONNAIRE. Although many of the STAI items do have face validity as measures of anxiety, directions for administration demand that the examiner not use this term in administering the inventory.

Normative data for the STAI scales are available for large samples of college freshmen, undergraduate college students and high school students. Normative data are also reported for male psychiatric patients, general medical and surgical patients and young prisoners.

The A-State Scale is considered "a sensitive indicator of the level of transitory anxiety experienced by clients and patients in counseling, psychotherapy, behavior therapy or on a psychiatric ward. It may also be used to measure changes in A-State intensity which occur in these situations. The essential qualities evaluated by the A-State scale involve feelings of tension, nervousness, worry and apprehension" (Spielberger et al., 1970, p. 3).

Validity of the A-State inventory depends upon the respondents having a clear understanding of the "state" instructions which require them to report how they feel "at this moment." The instructions may be modified to evaluate the level of A-State intensity for any situation or time interval that is of interest to the researcher, but the precise

period for which the subjects' A-State responses are desired must always be clearly specified. Participants in this study were instructed in the following way:

> Please think back during the past week to a situation which called for you to make an assertive response. In other words, you were called upon to express your feelings honestly and openly in a manner which took into account the feelings of the other person. It is not important whether or not you acted assertively, only that the incident occurred. Answer these questions as though you were in that situation. Try to pick a situation which was difficult for you.
>
> The following incidents were given as examples to those participants who needed further clarification.
>
> (1) Suppose you were in a clothing store. A sales clerk tries to sell you a garment by using flattery. You can tell that something doesn't look right on you, but the clerk keeps insisting that you really look good in it.
>
> (2) A good friend asks to borrow a book. When this person returns it, you find it has writing all over the margins and coffee stains on several pages. As she returns that book, she then asks to borrow another one.
>
> (3) Your neighbor calls you to do some charity work collecting money on your block. You have done the same job for the last three years and had not intended to do it again this year.

Test-retest correlations for the A-State Inventory were relatively low, as was expected for an instrument designed to be influenced by situational factors. The scale does, however, show a high degree of internal consistency as evidenced by alpha coefficients "computed by

formula K-R 20 as modified by Cronbach (1951) for the normative samples. These reliability coefficients ... ranged from .83 to .92 for A-State" (Spielberger et al., 1970, p. 10).

The STAI manual (Spielberger et al., 1970) reports evidence bearing on the construct validity of the A-State Scale. The A-State scale was administered to a group of college students under normal conditions with standard instructions. They were asked to respond according to how they believed they would feel just before an important final examination. Mean scores for the two testing conditions as well as critical ratios for the differences between these means and point-biserial correlations are reported. The mean score for A-State was considerably higher in the exam condition than in the norm condition for both males and females. Additional validity data for the A-State Scale was obtained in a study in which the scale was administered to 197 undergraduate students under four conditions in a single testing session. The first administration was at the beginning of the testing session (normal condition); the second followed a 10-minute period of relaxation training (relax condition). Then the students were asked to work on an IQ test and were interrupted after 10 minutes to take the scale a third time (exam condition). The last administration was immediately after the students viewed a stressful movie (movie condition).

The mean score for the A-State scale, as well as the scores for individual A-State items, were lowest in the relax condition and highest in the movie condition.

The A-Trait Scale reflects differences in peoples' dispositions to respond to stressful situations with varying amounts of A-State. "In general, it would be expected that those who are high in A-Trait will exhibit A-State elevations more frequently than low A-Trait individuals because they tend to react to a wide range of situations as dangerous or threatening. High A-Trait persons are also more likely to respond with increased A-State intensity in situations that involve interpersonal relationships which pose some threat to self-esteem" (Spielberger et al., 1970, p. 3).

Validity of the A-Trait Scale depends upon the respondents having a clear understanding of the "trait" instructions which require them to report how they "generally" feel. To preserve this validity the A-Trait scale will be administered before the A-State scale. This way the respondents will not be confused by the special set of instructions they will use for the A-State scale.

Test-retest reliability data for the A-Trait inventory showed relatively high correlations, ranging from .73 to .86. The scale shows a high degree of internal consistency as evidenced by alpha coefficients ranging from .86 to .92.

Correlations of the STAI with the IPAT Anxiety Scale, the Taylor Manifest Anxiety Scale (TMAS) and the General Form of the Zuckerman Affect Adjective Checklist (AACL) General Form resulted in evidence of the concurrent validity of the STAI A-Trait scale. The correlations

between the STAI, the IPAT and the TMAS were moderately high for college males and females and a population of general medical patients. Those correlations ranged from .75 between the STAI and the IPAT for college females to .80 between the STAI and the TMAS for college females. The STAI was only moderately correlated with the AACL, General Form.

Hypotheses

This study focused on hypotheses related to the effectiveness of assertion training. The following null hypotheses were tested.

1. There is no difference in women's level of assertion as a result of participation in an assertion training group.
2. There is no difference in women's level of state anxiety as a result of participation in an assertion training group.
3. There is no difference in women's level of trait anxiety as a result of participation in an assertion training group.
4. There is no difference in the number and intensity of symptoms expressed by women as a result of participation in an assertion training group.

Treatment Procedures

Jakubowski-Spector (1973) has suggested that assertiveness training for women is particularly effective when a group format is employed. The treatment in this study used a group format. Subjects in this study were assigned to either a treatment or a control group. There were six treatment groups with six to eight members in each group and 6 control groups with six to eight members in each group.

The procedure in this study involved two one-hour group sessions and five two-hour group sessions. The total treatment period was 12 hours. Sessions were held once a week for seven weeks. The one-hour sessions were the first and last meetings.

Pretests were given to the groups during the hour preceeding the first treatment session. Posttests were given at the end of the final treatment session.

The researcher led all of the groups. She has an M.Ed. degree and an Ed.S. degree in Counselor Education from the University of Florida and has completed all coursework and experience requirements for a doctoral degree. She is an experienced trainer who has been leading assertiveness training groups for four years. A copy of her vita is available in Appendix B.

The treatment method was a semi-structured assertiveness training procedure which incorporated a number of techniques the researcher has found successful in her previous assertiveness training experiences. An explanation of the seven treatment sessions can be found in Appendix G. The goals of the approach are those specified by Jakubowski-Spector (1973): the identification of personal rights and emotional blocks, the reduction of emotional blocks and the development of assertive behaviors through practice. The approach made use of the following techniques: group discussion focused on personal rights and emotional blocks, information giving, behavior rehearsal, role play reversal, modeling, coaching, feedback, reinforcement, analysis of nonverbal behavior and behavior assignments.

Design

The design used for this study was the randomized pretest-posttest control group design (Campbell and Stanley, 1963):

$$R\ O_1\ X\ O_2$$

$$R\ O_3\ \ O_4$$

R = Randomization

X = The Assertiveness Training treatment

O_1 = Pretest of training group members on the State-Trait Anxiety Inventory, the Assertiveness Inventory and the Hopkins Symptom Checklist

O_2 = Posttest of training group members

O_3 = Pretest of control group members

O_4 = Posttest of control group members

The subject recruitment process described earlier continued until a subject pool of 82 women was reached. The first 12 to 16 volunteers were assigned to either a treatment or a control group on the basis of times each subject indicated as convenient. These two groups of 6 to 8 each were then pretested. The members of the experimental group were tested as a group by the experimenter immediately before the first training session. The members of the control group were pretested within five days of the experimental group. An attempt to convene control subjects as a group failed, so they were tested on an individual basis. The experimental group received the treatment for seven weeks and was posttested immediately following the seventh training session. The control group received no attention during the seven-week period. They were posttested individually within five days of the experimental group.

The second 12 to 16 volunteers were similarly randomly assigned to either a treatment or a control group. The same testing procedure and timing was followed for this group that was described for the first group. The same occurred for the last groupings of volunteers. After 82 volunteers were assigned the researcher wrote a follow-up letter to the physicians (Appendix I) thanking them for their referrals and informing them of the cut-off date for referrals.

Analysis of the Data

This study focused on five demographic variables: age, educational level in terms of highest grade completed, number of children, race and employment. The data collection yielded pre- and postscores on the A-State and A-Trait Scales, on the Adult Self-Expression Scale and on the Hopkins Symptom Checklist and its five symptom clusters: somatization, obsessive-compulsivity, interpersonal sensitivity, depression and anxiety. Each of the experimental subjects also completed an evaluation of the training program.

The data collected for each subject were processed at the University of Florida computer center. Chi square analyses were used to evaluate the relationships between the treatment and the control groups on each of the demographic variables. Analyses of covariance, using pretest scores as covariates, were used to evaluate each of the nine scale scores on each of the demographic variables. Means and standard deviations also were computed for the evaluation forms.

In all comparisons, the 0.05 level of significance was established for testing the null hypotheses.

CHAPTER 4

RESULTS

Included in this chapter are description of subjects, discussion of attendance at the training sessions and analysis of the data.

Description of Subjects

All subjects completed a personal data form during the pretesting period (Appendix E). Breakdowns of responses are presented in Tables 1 through 6. All of the women were white.

Table 1

Age of Subjects

Age	Total	Experimental Groups	Control Groups
19-24	6	2	4
25-29	12	5	7
30-34	13	10	3
35-39	15	7	8
40-44	9	4	5
45-49	10	5	5
50-54	13	7	6
55-59	2	0	2
60-64	2	1	1
Mean Age	38.96	38.71	39.12

The compositions of both experimental and control groups evidence a representative cross section of age categories (Table 1). The experimenter had asked for referrals of women between the ages of 18 and 65 because her experience had been that younger and older women did not share enough commonalities to contribute to or benefit from a group of mixed ages.

Table 2

Marital Status

Marital Status	Total	Experimental Groups	Control Groups
Married	60	30	30
Single	7	4	3
Divorced	10	5	5
Widowed	5	2	3

The composition of the experimental and control group was also very balanced in terms of married, single, divorced or widowed members. Both the groups were comprised predominantly of women who were married at the time of the training.

Table 3

Years in Present Marriage

Number of Years	Total	Experimental Groups	Control Groups
1-5	11	3	8
6-10	9	5	4
11-15	7	5	2
16-20	9	5	4
21-25	12	6	6
26-30	6	4	2
31-35	5	1	4
36-40	1	1	0
Mean Years	16.80	17.63	15.97

Married subjects were evenly distributed between the treatment and control groups by how long they had been in their present marriages (Table 3). Both the groups had 18 members married 20 years or less and 12 members married 20 years or more. One third more subjects had been involved in marriages of 20 years or less duration than had been involved in marriages of 20 years or more duration.

As can be observed in Table 4, the subjects were almost evenly divided between the experimental and control groups according to how many children they had.

Table 4

Subjects' Numbers of Children

Number of Children	Total	Experimental Groups	Control Groups
0	15	7	8
1-2	45	23	22
3-4	19	10	9
5-6	2	0	2
7-8	1	1	0
Mean Number of Children	1.93	2.02	1.83

Fifteen subjects had no children. These 15 women were almost evenly divided between the experimental and control groups and made up less than one-fifth of the total sample.

Almost two-thirds of the sample had completed more than a high school education and one-half of those had completed a college degree or higher. These data are presented in Table 5.

Table 5

Subjects' Highest Grade Completed

Grade	Total	Experimental Groups	Control Groups
9	1	0	1
11	2	1	1
12	21	10	11
13	8	4	4
14	14	8	6
15	5	4	1
16	14	8	6
17	4	2	2
18	10	2	8
19	0	0	0
20	2	1	1
Mean Grade	14.45	14.33	14.56

The average subject had completed 14 1/2 years of school (Table 5). It clearly would be improper to try to generalize the results of this experiment to a population of women with less than a high school education.

The subjects' employment status is reflected in Table 6. Employed and unemployed women were well distributed between the treatment and control groups.

Table 6

Subjects' Employment Status

Employed	Total	Experimental Groups	Control Groups
Yes	45	25	20
No	37	16	21

Chi square analyses of the demographic data revealed that the treatment and the control groups were independent on each of these personal data variables (Table 7).

Table 7

Chi Square Analyses of Demographic Data

Variable	Degrees of Freedom	χ^2
Age	34	27.33
Marital Status	3	0.34
Years in Present Marriage	28	30.13
Number of Children	6	4.79
Highest Grade Completed	9	7.01
Employment	1	0.79

None of the chi square values were significant at the .05 level, which indicates that the sample was balanced between experimental and control groups.

Attendance

Eighty-two women were assigned to four treatment or four control groups. The groups had six to eight members each. Specific group compositions can be seen in Table 8.

Table 8

Number of Members in Each Group

Number of Members	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Total
Experimental	7	8	8	6	7	6	42
Control	7	8	8	6	7	5	41

Experimental group 6 had six members who participated in the assertive training. Only five of these women were actually experimental subjects. The sixth member was a control subject from group 1 who took her posttests as the other members took their pretests. She was added to experimental group 6 in an attempt to make it equivalent in size to the other experimental groups. She was not posttested as a member of experimental group 6.

The women were assigned to a group according to times they could attend. One person who took the pretests and attended the first session did not return thereafter; her data were therefore dropped from the analyses.

Participants in the experimental groups were told that it was very important for them to attend all of the training sessions. All of the women in the experimental groups either attended all of the sessions or attended a make-up session which was scheduled individually at a time before the next scheduled session for that individual. Twenty-five women attended all seven regularly scheduled sessions. Eleven women attended all but one of the regularly scheduled sessions and made up one session. Five women attended five of the regularly scheduled sessions and made up two sessions.

Members of the control groups were pre- and posttested individually. The researcher called each woman in the control group and arranged to administer the pretests to her individually either in her home or the experimenter's. The pretests were administered to the members of the control group within one week of the administration of the pretests to the members of the experimental groups. At the time the pretests were administered, the control subjects were told that they would be called in seven weeks and asked to take the instrument again. After a seven week interlude the members of the control group were called and told that they would receive the instruments in the mail within two days. They were asked to follow the directions printed on each instrument as they had done before. A self-addressed

stamped envelope was enclosed for the women to return the instruments to the researcher. The women were instructed to complete the instruments and return them to the researcher within five days after they received them. The members of the control group took the posttests within five days of their respective experimental group members.

Analysis of the Data

An analysis of the data is presented for each hypothesis tested.

Hypothesis 1

There is no difference in women's level of assertion as a result of participation in an assertion training group.

Table 9 depicts the results of the Analysis of Covariance on the Adult Self-Expression Scale.

Table 9

Analysis of Covariance on
the Adult Self-Expression Scale

Source	SS	df	MS	F
Covariates	20454.56	1	20454.46	75.16
Main Effects	5352.84	1	5352.84	19.67*
Explained	25807.30	2	12903.65	47.42
Residual	21499.37	79	272.14	
Total	47306.66	81	584.03	

*$p < .05$

The obtained F ratio of 19.67 was statistically significant at the .05 level, indicating that there was a difference in women's level of assertion as a result of participation in an assertion training group. The adjusted means (Table 10) show that this difference was in the direction of greater assertion as a result of the training. The postmeans are adjusted to eliminate random differences between the groups that existed before the treatment.

Table 10

Adjusted Mean Scores
for the Adult Self-Expression Scale

Group	Premean	Postmean	Adjusted Postmean
Experimental	98.71	120.44	124.41
Control	108.88	111.81	107.83

Hypothesis 2

There is no difference in women's level of state anxiety as a result of participation in an assertion training group.

Participants in this study were instructed to answer these questions in terms of how they felt when they were trying to be assertive during the past week. They were to pick a situation they considered challenging, not one they handled with ease.

Table 11 depicts the results of the Analysis of Covariance on the A-State Scale.

Table 11

Analysis of Covariance
on the A-State Scale

Source	SS	df	MS	F
Covariates	2933.81	1	2933.81	40.75
Main Effects	1229.56	1	1229.57	17.08*
Explained	4163.37	2	2081.69	28.91
Residual	5687.77	79	72.00	
Total	9851.14	81	121.62	

*$p < .05$

The obtained F ratio of 17.08 was statistically significant at the .05 level. This indicates that there was a significant difference in the women's level of state anxiety (present during times they were trying to be assertive) as a result of their participation in an assertion training group. The adjusted means (Table 12) indicate that this difference was in the direction of less state anxiety as a result of the training.

Table 12

Adjusted Mean Scores for the A-State Scale

Group	Premean	Postmean	Adjusted Postmean
Experimental	57.05	44.46	43.15
Control	51.78	49.73	51.05

Hypothesis 3

There is no difference in women's level of trait anxiety as a result of participation in an assertion training group.

The instructions on the A-Trait Scale indicate that all respondents are to answer the questions according to how they generally feel.

The results of the Analysis of Covariance on the A-Trait scale can be inspected in Table 13.

Table 13

Analysis of Covariance on the A-Trait Scale

Source	SS	df	MS	F
Covariates	4239.94	1	4239.94	65.02
Main Effects	291.74	1	291.74	4.47*
Explained	4531.67	2	2265.84	34.75
Residual	5151.24	79	65.21	
Total	9682.91	81	119.54	

*$p < .05$

The obtained F ratio of 4.47 was statistically significant at the .05 level. This indicates that there was a difference in women's levels of trait anxiety as a result of participation in an assertion training group. The adjusted means (Table 14) show that this

difference was in the direction of less trait anxiety as a result of the training.

Table 14

Adjusted Mean Scores for the A-Trait Scale

Group	Premean	Postmean	Adjusted Postmean
Experimental	45.63	38.95	36.74
Control	39.56	38.46	40.68

Hypothesis 4

There is no difference in the number and intensity of symptoms expressed by women as a result of participation in an assertion training group.

To test this hypothesis this study used a total score on the Hopkins Symptom Checklist as well as the scores for its five basic underlying symptom clusters: somatization, obsessive-compulsivity, interpersonal sensitivity, depression and anxiety. The results for each of these measurements will be discussed individually.

HSCL Total Score: Table 15 depicts the results of the Analysis of Covariance on the HSCL Total Scores.

Table 15

Analysis of Covariance on
the Hopkins Symptom Checklist Total Score

Source	SS	df	MS	F
Covariates	10721.12	1	10721.12	57.52
Main Effects	2408.53	1	2408.53	12.92*
Explained	13129.65	2	6564.82	35.22
Residual	14724.80	79	186.39	
Total	27854.45	81	343.88	

*$p < .05$

The obtained F ratio of 12.92 was statistically significant at the .05 level, indicating that there was a difference in women's total symptom configurations as a result of participation in an assertion training group. The adjusted means (Table 16) show that this difference was in the direction of fewer and less intense symptoms as a result of the training.

Table 16

Adjusted Mean Scores
for the Hopkins Symptom Checklist Total Score

Group	Premean	Postmean	Adjusted Postmean
Experimental	102.12	88.02	85.21
Control	93.59	93.51	96.33

HSCL-Somatization: The results of the Analysis of Covariance on the Somatization dimension of the HSCL can be inspected in Table 17.

Table 17

Analysis of Covariance on the
Hopkins Symptom Checklist Somatization Dimension

Source	SS	df	MS	F
Covariates	845.57	1	845.57	77.92
Main Effects	128.17	1	128.17	11.81*
Explained	973.74	2	486.87	44.86
Residual	857.23	79	10.85	
Total	1831.02	81	22.61	

*$p < .05$

The obtained F ratio of 11.81 was statistically significant at the .05 level indicating that there was a difference in the women's amounts of somatization after participation in an assertion training group. The adjusted means (Table 18) show that this difference was in the direction of less somatization as a result of the training.

Table 18

Adjusted Mean Scores for the
Hopkins Symptom Checklist Somatization Dimension

Group	Premean	Postmean	Adjusted Postmean
Experimental	18.00	16.44	16.38
Control	17.85	18.83	18.88

HSCL-Obsessive-Compulsive: Table 19 depicts the results of the Analysis of Covariance on the Obsessive-Compulsive dimension of the HSCL.

Table 19

Analysis of Covariance on the
Hopkins Symptom Checklist Obsessive-Compulsive Dimension

Source	SS	df	MS	F
Covariates	370.91	1	370.907	48.70
Main Effects	63.68	1	63.68	8.36*
Explained	434.59	2	217.29	28.53
Residual	601.71	79	7.62	
Total	1036.30	81	12.79	

*$p < .05$

The obtained F ratio of 8.36 was statistically significant at the .05 level indicating that there was a difference in women's obsessive-compulsivity as a result of participation in an assertion training experience. The adjusted means (Table 20) show that this difference was in the direction of less obsessive-compulsivity as a result of the training.

Table 20

Adjusted Mean Scores for the
Hopkins Symptom Checklist Obsessive-Compulsive Dimension

Group	Premean	Postmean	Adjusted Postmean
Experimental	15.00	12.83	12.56
Control	14.02	14.07	14.34

HSCL-Interpersonal Sensitivity: Table 21 depicts the results of the Analysis of Covariance on the Interpersonal-Sensitivity dimension of the HSCL.

Table 21

Analysis of Covariance on the
Hopkins Symptom Checklist Interpersonal-Sensitivity Dimension

Source	SS	df	MS	F
Covariates	144.37	1	144.37	20.74
Main Effects	33.48	1	33.48	4.81*
Explained	177.85	2	88.93	12.77
Residual	550.05	79	6.96	
Total	727.90	81	8.99	

*$p < .05$

The obtained F ratio of 4.81 was statistically significant at the .05 level, indicating that there was a difference in the women's interpersonal sensitivity as a result of participation in an assertion training experience. The adjusted means (Table 22) show that this change was in the direction of less interpersonal sensitivity as a result of the training.

Table 22

Adjusted Mean Scores for the
Hopkins Symptom Checklist Interpersonal-Sensitivity Dimension

Group	Premean	Postmean	Adjusted Postmean
Experimental	13.73	11.34	10.92
Control	11.95	11.83	12.26

HSCL-Anxiety: The results of the Analysis of Covariance on the Anxiety dimension of the HSCL can be inspected in Table 23.

Table 23

Analysis of Covariance on the
Hopkins Symptom Checklist Anxiety Dimension

Source	SS	df	MS	F
Covariates	167.21	1	167.21	37.80
Main Effects	36.61	1	36.61	8.28*
Explained	203.82	2	101.91	23.04
Residual	349.46	79	4.42	
Total	553.28	81	6.83	

*$p < .05$

The obtained F ratio of 8.28 was statistically significant at the .05 level, indicating that there was a difference in the women's anxiety after the assertion training experience. The adjusted means (Table 24) show that this change was in the direction of less anxiety as a result of the training.

Table 24

Adjusted Mean Scores for the
Hopkins Symptom Checklist Anxiety Dimension

Group	Premean	Postmean	Adjusted Postmean
Experimental	12.24	10.34	9.93
Control	10.83	10.90	11.31

HSCL-Depression: The results of the Analysis of Covariance on the HSCL dimension of Depression are depicted in Table 25.

Table 25

Analysis of Covariance on the
Hopkins Symptom Checklist Depression Dimension

Source	SS	df	MS	F
Covariates	700.27	1	700.27	47.56
Main Effects	47.15	1	47.15	3.20
Explained	747.42	2	373.71	25.38
Residual	1163.17	79	14.72	
Total	1910.59	81	23.59	

The obtained F value of 3.20 did not reach the .05 level of significance. Therefore, we cannot say that there was a significant

difference in the symptom depression after training. The adjusted means (Table 26) do indicate that what change did occur was in the desired direction of less depression, however.

Table 26

Adjusted Mean Scores for the
Hopkins Symptom Checklist Depression Dimension

Group	Premean	Postmean	Adjusted Postmean
Experimental	20.66	17.71	16.99
Control	18.27	17.83	18.55

The F ratio for the subscale Depression was not statistically significant at the .05 level. Therefore, on the basis of the analyses there was no significant difference in the symptom Depression as a result of participation in an assertion training group. However, differences in the Somatization, Obsessive-Compulsive, Interpersonal-Sensitivity and Anxiety subscales and on the Total Score were all significant at the .05 level. This indicates that there was a difference in the number and intensity of symptoms expressed by women as a result of participation in an assertion training group. The adjusted means show that this change was in the direction of fewer and less intense symptoms.

Evaluation of Training

An Evaluation Form (Appendix F) containing six multiple-choice items was administered as a posttest. Forty of the 41 women in the experimental group completed the form. Respondents were instructed to circle the appropriate letter of their choice (a. excellent, b. very good, c. good, d. fair, e. poor). For scoring purposes a = 1, b = 2, c = 3, d = 4 and e = 5. Means and standard deviations for each question may be found in Table 27.

Table 27

Means and Standard Deviations
for the Treatment Evaluation Form

Evaluation Questions	Mean	S.D.
I thought the training program was: a. excellent b. very good, c. good, d. fair, e. poor	1.38	0.49
The ideas and materials presented by the leader were: a. excellent, b. very good, c. good, d. fair, e. poor	1.30	0.52
The way the material was presented was: a. excellent, b. very good, c. good, d. fair, e. poor	1.38	0.54
The behavior rehearsal experiences were a. excellent, b. very good, c. good, d. fair, e. poor	1.80	0.69
The help I received from the group leader was: a. excellent, b. very good, c. good, d. fair, e. poor	1.55	0.55
The help I received from other members of the group was: a. excellent, b. very good, c. good, d. fair, e. poor	2.05	0.82

Note: For scoring purposes a = 1, b = 2, c = 3, d = 4, e = 5.

Most of the comments about the assertive training experience were very favorable. The means for the first five questions all placed between excellent and very good. These questions were directed at ascertaining the group members' responses to the training experiences and to the leader. Question 4, which asked for an evaluation of the behavior rehearsal experiences, had the highest mean of these first five, which indicates a less favorable response to that question. This could reflect the fact that not all participants seemed as comfortable or willing as others to participate in the behavior rehearsal exercises. Question 6 was directed at ascertaining the group members' responses to one another. Their mean response, though not as positive as for the other five questions, did fall between very good and good.

A number of the group members added statements commenting on the effectiveness of their group experience. These are cited in Appendix J.

These self-report measures are of limited significance except in giving subjective impressions of the effectiveness of the groups. The basic purpose of the groups was to aid in establishing better communications and to reduce women's anxieties and symptomatizations. The fact that the women reported benefits from the group cannot be ignored.

CHAPTER 5

SUMMARY, LIMITATIONS, DISCUSSION AND IMPLICATIONS

Summary

The purpose of this study was to investigate whether assertion training, using well-defined and researched procedures, could effectively modify anxiety and symptomization in a population of women referred by their physicians. The women all reported anxiety of an interpersonal nature which they experienced symptomatically. Specifically, the study investigated four main hypotheses:

1. There is no difference in women's level of assertion as a result of participation in an assertion training group.
2. There is no difference in women's level of state anxiety as a result of participation in an assertion training group.
3. There is no difference in women's level of trait anxiety as a result of participation in an assertion training group.
4. There is no difference in number and intensity of symptoms expressed by women as a result of participation in an assertion training group.

Eighty-two women were referred by their primary-care physicians for the training. These women were assigned to one of six treatment or six control groups. Members of the experimental groups were tested,

received assertion training and were posttested. Members of the control groups were tested, waited seven weeks and were posttested.

All 82 women provided all the data requested. Data consisted of scores on nine criterion variables: the Adult Self-Expression Scale, the A-State Anxiety Scale, the A-Trait Anxiety Scale and the Hopkins Symptom Checklist which yields a total score and a score on five subscales (Somatization, Interpersonal-Sensitivity, Obsessive-Compulsive, Anxiety and Depression). Pre- and postscores on all of the instruments were totaled for all subjects. Subjects also completed a Personal Data Form. Forty members of the experimental group filled out a form evaluating the training after the training period.

Chi square analyses were used to evaluate the differences between the treatment and the control groups on the demographic data. Group assignment was shown to be independent of the personal data variables.

Analyses of covariance, using pretest scores as covariates, were used to evaluate each of the nine scale scores. The analyses produced results significant at the .05 level for all variables except the Depression subscale of the Hopkins Symptom Checklist.

Means and standard deviations were computed for items of the evaluation forms. Most of the participants' comments were very favorable.

Based upon these statistical findings, the assertive training group was better than the control group in developing assertive behavior, in lessening general and situation-specific anxiety and in

lessening the women's somatization, obsessive-compulsivity, interpersonal-sensitivity, anxiety and total symptom configurations.

Limitations

This study has the following limitations which suggest recommendations for future research.

1. A lack of true randomization in assignment of the women to either treatment or control group somewhat limits the generalizability of the results. However, the chi square analyses of the demographic data did reveal that there were no significant differences between the experimental and control group on any of the demographic variables. With this type of population it is very difficult to maintain subject interest long enough to assure random assignment to treatment or control group. Scheduling individuals in a two-hour group once a week for seven weeks is especially difficult when not dealing with individuals in an institutional setting.
2. The researcher administered and scored all of the inventories herself. This could possibly introduce an element of experimenter bias. The researcher is not aware of that having occurred.
3. There was no in-vivo test of assertion used. Since a very important part of becoming more assertive is developing a belief in oneself and an assertive attitude, this instrument is effective. However, it might be of further value to include an in-vivo test in future research.

4. To control for attitudinal lag or lapses which may occur when training is suspended, future studies should consider using a posttest measurement in a time span sequence.

Discussion

An assertion training experience appears to have a definite effect on the assertion skills, anxiety and symptomization of a normal group of white women referred by their physicians. The results of this study indicate systematic effects among an assertion training experience and the criterion measures selected for investigation.

The statistical findings in this study indicate that members of the experimental group did significantly increase assertive behavior after participation in an assertive training group. This is in line with the results of earlier studies (Rathus, 1973; Kazdin, 1974, 1975, 1976). These results also confirm earlier findings that techniques such as behavior rehearsal (McFall & Lillesand, 1971; McFall & Marston, 1970) and behavior assignments (Rathus, 1973) are effective tools in training persons to become more assertive.

The main ASES total score obtained from 640 adults ranging in age from 18 to 60 was approximately 115 with a standard deviation of approximately 20 (Gay, 1974). This means that ASES scores falling around 135 are considered high scores while those falling below 95 could be considered low. The 124.41 adjusted mean of the experimental group puts the average of posttest scores of the experimental group in the high assertive range.

Some of the literature reviewed in Chapter 2 revealed that assertive training has helped persons become less anxious (Percell, 1974; Rathus, 1973; Rimm, Hill, Brown and Stuart, 1974). The significant results for the assertive training group on the A-Trait and A-State scales add credence to those findings. It follows that if women become less anxious in situations calling for them to be assertive they will be able to be assertive more often and consequently become less anxious in general.

The assumption in this study was that if the assertion training is effective in reducing the levels of state and trait anxiety in women, the level and intensity of symptomization would also be reduced. A number of conclusions can be drawn from the Hopkins Symptom Checklist data. The HSCL is scored on the basis of five symptom clusters: somatization, interpersonal-sensitivity, obsessive-compulsivity, depression and anxiety. This study also used a total score for the Checklist which included answers for the five dimensions plus 14 items from the scale which were not included in any dimension. The experimental groups were significantly different from the control groups in the direction of less symptomization on all dimensions, except depression, and also on the total score.

The items which comprise the dimension somatization reflect distress arising from perceptions of bodily dysfunction. Twelve items contribute to the dimension including complaints such as headaches, backaches and other somatic equivalents of anxiety. Possible scores ranged from 12 to 48. The ANOCOVA indicated a significant change for

the better on this dimension. The adjusted mean of 16.38 for the experimental group would indicate that on the average the women in these groups were not severely distressed by these types of symptoms.

The focus of the obsessive-compulsive measure is on thoughts, impulses and actions that are experienced by the individual as irresistable and unremitting. They are at the same time of an unwanted nature. Behaviors indicative of a more general cognitive difficulty (e.g. mind going blank, trouble remembering) also are part of this eight item dimension. Possible scores range from 8 to 32. Experimental subjects also differed significantly from control subjects on this dimension. They became less likely to experience obsessive-compulsive symptoms.

The interpersonal-sensitivity dimension is made up of seven items which focus on feelings of personal inadequacy and inferiority, particularly in comparison with other individuals. The ANOCOVA indicated a significant change for the better on this dimension which should be an indicator that the women are experiencing less discomfort during interpersonal interactions and fewer feelings of uneasiness and self-deprecation. Scores on this dimension range from 7 to 28. The adjusted mean of 12.26 for the experimental group indicates that the women in these groups were not seriously bothered by feelings of interpersonal sensitivity.

Women in the experimental group changed significantly on the HSCL dimension of anxiety in the direction of less anxiety. This measure includes general indicators of anxiety such as restlessness

and nervousness as well as some somatic signs, e.g. trembling. This dimension is composed of six items, with possible scores from 6 to 24. The adjusted mean of 11.31 for the experimental group suggests that anxiety might have been more of a problem for the women than the other symptom dimensions. However, it is still not high enough to suggest a serious problem.

Eleven items make up the dimension of depression. They include complaints such as withdrawal of interest in activities, lack of motivation, lack of energy and feelings of hopelessness and futility. Possible scores range from 11 to 44. There was no significant change on this dimension. This could be attributable to the fact that two experimental subjects reported experiencing a state of personal depression at the time of posttesting. Their scores on the depression scale at posttesting reflected this state.

Implications

Several factors seem to be especially significant in discussing why women are anxious. Stresses arising from potentially conflicting social roles can create problems for women that lead to anxiety. Women today are also caught between conforming to existing standards or role definitions and exploring the promise of new alternatives. Often, as women assess their individual potentials for self-growth, they notice inadequacies in their abilities to fulfill their aspirations. Anxiety often inhibits their trying out new roles and seeking new relationships. Thus, many women are caught in the paradoxical situation

of experiencing anxiety within their existing situations or roles (trait anxiety) and at the same time experiencing anxiety (state anxiety) as they try out new behaviors which might alleviate those anxieties.

Anxiety can be treated. As discussed in Chapter 1, since many individuals first manifest anxiety symptomatically, they often approach their physician for help. Medical treatment often takes the form of drug therapy which can be expensive and in some cases debilitating. Moreover, treating the symptom or somatic manifestation of the anxiety does not help the patient identify and learn to cope with the anxiety-provoking situation.

The psychological treatment of anxiety has traditionally involved extended and intensive psychotherapeutic relationships. Such methods can be expensive and time-consuming and are frequently not available to the vast majority of people. Also, Chesler (1971) has suggested that for many women the psychotherapeutic encounter is just one more power relationship in which they are rewarded for expressing distress and are helped by submitting to a dominant authority figure, thereby creating more anxiety.

This study shows that assertion training is an effective treatment for reducing women's anxiety. The training is based upon the principle of increasing women's adaptive behaviors and helping them focus their emotional energy on alleviating specific difficulties or problems. Along with this lessening of anxiety, the assertion training also precipitated a reduction in the level and intensity of the women's symptomatic manifestations of that anxiety. Since this particular

technique does in fact significantly increase assertion and decrease anxiety and symptomization, it can be stated that we have an effective methodology that is (1) socially acceptable, (2) easily taught and (3) relatively easy for participants to understand and learn. Thus, an important implication of this study is that we have a methodology which is a viable alternative to the use of either medical intervention or extended psychotherapeutic relationships for the treatment of anxiety and its consequent symptomization.

Along with this implication for practice are two other considerations. The first has to do with counselor training. Assertion training has been shown to be a methodology which is helpful to a group of women who represent a large segment of our population - namely, those women who are afflicted with anxiety, who exhibit symptoms of that anxiety and who report these symptoms to their physicians. As such, it should be an important part of training programs for counselors since it provides them with another technique to use.

Secondly, these findings have an important implication for future research. Assertion training has been shown to be effective in reducing women's anxiety and symptomization. It remains to be shown exactly why the training works. Future research might explore what it is specifically that makes it effective, e.g. the particular leadership style, attendance or specific activities.

APPENDICES

APPENDIX A

Doctor's Letter

February 2, 1978

Dear Doctor:

For my doctoral dissertation I am studying the effect of a psychological treatment program on anxious women. I am interested in involving women who periodically experience stress induced symptoms and who come to their physician for treatment. This program will be offered only as an adjunct to the individual's physician's prescribed treatment plan. It is psychological in nature but primarily involves the building of new interpersonal skills rather than indepth personal exploration or therapy.

I am writing to request your assistance in referring patients to my study. I am interested in women ranging in age from 20 to 65 who, in your estimation, are experiencing one or more of the following symptoms as a consequence of anxiety:

1. Somatic Complaints: e.g. headaches, gastro-intestinal distress, muscle soreness, chest pain, faintness or dizziness;

2. Interpersonal Hypersensitivity: e.g. feeling critical of others, easily annoyed or irritated; experiencing temper outbursts or feelings of inferiority;

3. Depression: e.g. loss of sexual interest or pleasure, poor appetite, crying easily, feeling blue or worrying or stewing about things; or

4. Anxiety: e.g. feeling fearful, nervous, shaky, tense or keyed up or heart pounding or racing.

These women may be receiving psychotherapeutic drug therapy, but that is not a necessary criterion for referral. Patients with evidence of organicity, psychosis, addictive disorder or sociopathy will be excluded.

The program will be offered free of charge. It will involve seven weeks of group experience to take place during February, March and April, 1978. I have had extensive experience in conducting groups of this nature, and I will be doing all of the training. My vita is enclosed. The research part of the study will involve the administration of three psychological inventories before and after the training. I will be glad to report back to you about your patient's progress at the end of the training.

I would appreciate your mentioning this opportunity to your patients who meet these criteria. I have included several copies of a letter to your patients with cards for them to return to me if they are interested in the training. I will get in touch with you soon to answer any questions you might have and to find out if you need more letters. Dr. Wilmer Coggins, a faculty member in the Department of Community Health and Family Medicine, is providing medical sponsorship for this project. All patients will remain under your direct management, but he has agreed to answer any questions you might wish to address to a physician.

Thank you for your consideration.

Sincerely yours,

Trudy Gies Little, M.Ed.,
Ed.S.
1719-PHF NW 23 Avenue
Gainesville, FL 32605

Telephone: 378-5000 or
376-2672

APPENDIX B

Gertrude Gies Little
Personal and Professional Data

PERSONAL

Home Address:	1719-PHF NW 23 Avenue, Gainesville, Florida 32605
Telephone:	(904) 378-5000
Date of Birth:	February 14, 1947
Place of Birth:	Erie, Pennsylvania
Marital Status:	Married

PROFESSIONAL PREPARATION

Ph.D.		Counselor Education, University of Florida (expected August, 1978)
Ed.S.	1971	Counselor Education, University of Florida
M.Ed.	1971	Counselor Education, University of Florida
B.A.	1968	Philosophy, St. Marys College, Notre Dame, Indiana

PROFESSIONAL EXPERIENCE

March 1974 to December 1977	Instructor, Assertiveness Training for Women, Santa Fe Community College, Gainesville, Florida
September 1971 to March 1975	Instructor, Department of Behavioral Studies, University of Florida
September 1971 to August 1974	Assistant to the Coordinator of Practicum and Internship, Department of Counselor Education, University of Florida
September 1969 to June 1971	Resident Advisor, University of Florida residence halls
	Two years of supervised counseling experience in placements such as Lowell Prison, Santa Fe Community College, and the University of Florida Office for Student Development

PROFESSIONAL AFFILIATIONS

American Personnel and Guidance Association
American College Personnel Association

APPENDIX C

Patient's Letter

Hello!

Your doctor has suggested that you might benefit from working with me in a program I am currently conducting. I have asked him(her) to give you this letter, so that I could tell you a little more about the experience I am offering. This program is designed for women. It is intended to help women become more effective in their interpersonal relationships. What it will involve for you is meeting in a group with several other women and receiving some interpersonal skills training. I have had extensive experience in conducting groups of this nature, and I will be doing all of the training. At the end of the program I will be glad to give both you and your doctor feedback about your progress.

There will be no charge for the program. Each group will meet for two hours once a week for seven weeks at a time which is convenient for the members. Some women will begin the training in February, others in April. You will also be asked to fill out several questionnaires to help me evaluate the effectiveness of the training.

If you decide to participate in the program you should plan to attend all the sessions, since the training can be effective only if you are there. The time periods are listed on the attached card. Please indicate your first three preferences. I will make every effort to accommodate you.

If you are interested, or if you would like more information, just drop the card in the mail. I will be glad to answer any of your questions. I look forward to meeting you.

Sincerely yours,

Trudy Gies Little
1719-PHF NW 23 Avenue
Gainesville, FL 32605

Telephone: 376-2672 (an answering service will take a message and I will call you back)

APPENDIX D

Postcard

NAME _____ PHONE_____

ADDRESS _____

_____ Please call as I need more information

_____ Yes, I want to participate and have indicated at least three (3) times I am available.

Please check three times you could attend

Times	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SAT
10:00-12:00						
1:00-3:00						
3:00-5:00						
7:00-9:00						

APPENDIX E

Personal Data Sheet

Name _____

Age _____ Race _____

Marital Status _____

Number of Years in Present Marriage _____

Number of Children _____

Highest Grade Completed in School _____

Are you employed? _____

APPENDIX F

Evaluation Form

Name _____

The researcher would appreciate your taking time to fill out this evaluation of the training program. Please circle the letter of the proper answer.

1. I thought the training program was:

   a. excellent b. very good c. good d. fair e. poor

2. The ideas and material presented by the leader were:

   a. excellent b. very good c. good d. fair e. poor

3. The way the material was presented was:

   a. excellent b. very good c. good d. fair e. poor

4. The behavior rehearsal experiences were:

   a. excellent b. very good c. good c. fair e. poor

5. The help I received from the group leader was:

   a. excellent b. very good c. good c. fair e. poor

6. The help I received from other members of the group was:

   a. excellent b. very good c. good c. fair e. poor

Please write any comments you wish to make about the experience below (use back if necessary).

APPENDIX G

Treatment Procedures

First Session (one hour)

I. Introduction and welcome

A. Leader introduces self briefly

B. Group members introduce selves and share something about their background

II. Short background and history of assertive training

III. Why assertive training for women

A. burgeoning interest in self-fulfillment and in self-actualization

B. new options for women and flexible opportunities

C. women's movement - new permission to be strong and effective

IV. Brief explanation of assertive training procedure and goals

V. Establish certain ground rules

A. confidentiality - everything disclosed within the group is not to be discussed outside of the group

B. explanation of the participants' responsibility to each other - their need to help others and receive help from others

C. passing - each person must feel free to refuse to participate

D. discomfort - if a participant is unhappy with the way things are going it is her responsibility to express this to the group

VI. Go over dates and times of sessions and the importance of their participation in each session

VII. Assignment: Participants are not to try to change their behavior but rather to observe

A. How do you handle conflict

1. How do you get what you want without directly asking (e.g. flirting, whinning)?

2. What message did your parents give you about handling conflict (e.g. children should be seen and not heard)?

B. Try to identify during the week times their needs are not being met

Second Session (two hours)

I. Comparison of nonassertive, assertive and aggressive behavior (Alberti & Emmons, 1974).

A. Use of blackboard and member participation in discussing

1. characteristics of the behavior

2. your feelings during the behavior

3. other person's feelings about self at time

4. other person's feelings about you

B. Define nonassertion, direct and indirect aggression, assertion

C. Talk about projection

II. Discuss needs

A. Identification of needs

B. Expression of your needs to others

C. Last weeks' assignment - what they noticed

C. Nonassertive circle (engage in behavior to protect a relationship; build up resentment and end up hurting the relationship)

E. Hidden bargain (I've struck a bargain with you that you don't know anything about)

III. Identify interpersonal rights and responsibilities

A. Discuss refusal rights and responsibilities

B. Have group brainstorm their own list of basic rights (e.g. right to feel and express anger, right to have one's needs be as important as the needs of other people)

C. Rights without guilt

D. Limitations and responsibilities

1. have refusal rights even if the other person badly wants the request, is emotionally sick or an authority figure - a limitation would be a prior commitment

2. have right to express needs even if the other person doesn't want to hear them - a limitation would be the responsibility not to use other people

3. role of compromise

IV. Assignment: Participants are encouraged not to try to change their behavior but rather to observe times during the week that they are assertive, nonassertive or aggressive. Notice

A. When does each happen, e.g. time of day

B. Does a particular behavior evidence itself most frequently with a particular person, e.g. spouse, boss, children

C. Do certain situations provoke certain behaviors e.g. are you assertive at home but never at work

D. Participants are asked to write down their observations to refresh their memories at the next class

Third Session (two hours)

I. Discuss assignment from previous week

II. Discuss positive or soft assertions: giving and receiving compliments

A. Rationale

1. expressing positive, caring feelings frequently more difficult than "standing up" behaviors due to a fear of embarassment or ridicule

2. people learning to express negative feelings should also be able to express positive feelings

B. Explain how such behaviors also require assertiveness

C. Distinguish between healthy self-pride and egotism

III. Exercises for soft assertions

A. Group members describe or act out ways in which persons respond to compliments that would make the giver unlikely to offer another compliment

1. denying shyly (Oh gosh, who me?)
2. returning the focus at once (Oh, I like your blouse a lot, too)
3. rejecting (This old rag, I've had it for years)

B. Group members act out negative ways of giving a compliment
1. self-deprecating (I'm not a very good mother but you're so great)
2. sarcastic (Those pants really do fit well, don't they!)
3. crooked (Most people don't like you but I do)

C. Each person gives a compliment to the person on their right and that person responds; they interact briefly; then the receiver turns to compliment the person on her right. Then each giver expresses to the receiver something she liked about how the receiver responded to her compliment

IV. Discuss components of assertive behavior (Alberti & Emmons, 1974)

A. eye contact
B. body posture
C. gestures
d. facial expression
e. voice tone, inflection, volume
f. timing
g. content of what you are saying

V. Assignment: participants are asked to

A. Give three compliments during the following week and assess how comfortable and how direct they are

B. Observe how they react when the receive compliments and assess how comfortable they are and how assertively they respond

C. Make several positive self-statements

D. Note which components of assertive behavior they have trouble with

E. Write down their observations to refresh their memories at the next class

F. Start identifying situations in their everyday lives that they might work on in class

Fourth Session (two hours)

I. Leader clarifies types of assertive responses

A. Simple assertion - uncomplex, simple statements

B. Empathic assertion - includes recognition of the other person's state or situation

1. explain reflection

2. differentiates between reflection of feeling and reflection of content

C. Assertions which include expression of your own feelings in a situation (either positive or negative)

1. discuss the importance of identifying and owning your own feelings
2. suggest as a model the formula I feel (feeling) when (situation or behavior) because (effect on your life in concrete way). I'd prefer (what behavior you would prefer).

II. Distinguish between proactive and reactive assertion

III. Begin behavior rehearsal of situations the participants wish to work on. Group members should be encouraged to become familiar with the process involved

A. Clarify the situation

1. what is your goal for this assertive interaction
2. is your goal reasonable

B. Behavior rehearsal offers participants a chance to practice assertion in a safe setting and lets group members learn by watching each other

1. a group member plays herself, the leader plays other person; the interaction is taped
2. the recording of the interaction is played back and the group member involved receives feedback from the leader and other group members
3. the client then plays the other person while the leader plays the client and models good assertive responses; the interaction is taped

4. the tape is played back, feedback is given and roles are reversed again
5. the client plays herself and the leader plays the other; the leader makes responses which make it increasingly difficult for the client to handle

C. Stress the importance of positive feedback and support from group members; feedback should be specific about verbal and nonverbal behavior

IV. Assignment: Group members are encouraged to practice making the three basic types of assertive responses. They are to keep track of their eye contact, gestures, etc.

Fifth Session (two hours)

I. Discuss assignment from previous week. Allow an opportunity to rehearse in class those situations which members found difficult

II. Discuss irrational beliefs which might inhibit assertion

A. Individuals frequently focus on only one outcome, e.g., the worst possible one

B. Participants are encouraged to think of all possible outcomes

C. Brainstorm irrational beliefs

D. Discuss concept of escalation

III. Class does an exercise geared to helping participants recognize and cope with negative responses often incurred while making and/or refusing requests

A. Four class members form a line

B. The person at the top of the line goes through the line and either makes a request of or refuses a request from each person in the line

C. Individuals react by ignoring or by trying to make the person going through the line feel guilty, or by getting angry

IV. In refusing a request group members should be encouraged to

A. Assess whether the request is reasonable

B. Practice saying no without long winded statements of excuses, justifications or rationalizations

C. Drop the use of disclaimers, e.g., "I'm sorry but"

D. Most importantly think over the decision before responding

1. do I really want to do it

2. if I decide to do it will it be rewarding now and later

V. Assignment: class is encouraged to find a partner outside of class to rehearse new behaviors with. They are given the following guidelines

A. Basic rules to follow

1. keep scenes simple and specific

2. use scenes from real life

3. give partner specific instructions about how to play the role you want him/her to play

4. start with easy situations and work up to more difficult ones
5. try to become aware of stimuli which causes you difficulty e.g., a frown, tone of voice and add them to the scene

B. Under content they are encouraged to look at the following factors
   1. did I face the real problem
   2. does my solution resolve the problem
   3. did I communicate what I wanted to communicate
   4. did I avoid being compliant
   5. did I clearly request a new behavior from the other person

C. Under mode of expression
   1. was my voice sufficiently loud and firm
   2. did I talk too long and overexplain
   3. did I talk long enough to make myself understood
   4. did my voice, expression and gestures communicate what I felt

Sixth Session (two hours)

I. Discussion of assignment from previous week. Allow an opportunity to rehearse in class those situations which members bring in.

II. Discuss potential adverse reactions to assertive behavior (Alberti & Emmons, 1974); rehearse coping strategies

A. backbiting

B. aggression

C. temper tantrums

D. psychosomatic reactions

E. overapologizing

F. revenge

III. Assignment: same as for Session Five

Seventh Session (one hour)

I. Discussion of assignment from previous week. Short rehearsal of problem situations

II. Discuss specific times women might choose to not assert themselves (Alberti & Emmons, 1974).

1. redundancy

2. being understanding

3. when you are wrong

III. Discuss with the group members

1. what they will continue to work on

2. what methods will I use

3. contracting

APPENDIX H

Consent Form

You are being asked to participate in a research project that has been designed to study the effectiveness of assertiveness training in helping women feel better about themselves. Individuals generally find that they benefit from the training.

All participants will be asked to fill out a personal data sheet and three paper and pencil inventories before and after the treatment period. There will also be a brief evaluation form to fill out after the training program. Your name will be coded so your identity and responses will remain anonymous. Only this experimenter will have access to the data; she will destroy it after she has analyzed it for research purposes.

Your participation in this project is completely voluntary. You have the right to withdraw at any time. You also have the right to ask questions of the experimenter either now or at any time during the study.

I have read and I understand the procedure described above and I agree to participate in the procedure. I have received a copy of this description.

_____ _____

Name Date

_____ _____

Researcher's Name Date

APPENDIX I

Second Doctor's Letter

April 14, 1978

Dear Doctor,

I am writing to thank all of you who have referred patients to my study about women who receive assertiveness training. I also wanted to tell you that I will be accepting referrals for this project only until Friday, April 21.

At present there are 72 women involved in the program. I anticipate that all of the training and the analysis of the data will be completed by August 1. When I have the results I shall send you a report of my findings.

Once again thank you very much for your attention.

Sincerely,

Trudy Gies Little
1719-PHF NW 23 Avenue
Gainesville, FL 32605

376-2672 (answering service)
378-5000 (home)

APPENDIX J

Experimental Group Members' Comments

Group I

-I am very happy I participated. I have learned a tremendous amount of valuable information not only about myself but about others. I feel able to communicate more effectively, to listen better and to feel good!

-I am very sorry the group is over. I feel like it has helped reinforce the positive areas in my life which has made me able to accept and work on the negative areas. I was having a hard time even looking at the positive side much less work on the negative areas. Thanks.

Group II

-During this difficult period of my life, this program was a really terrific experience. If I haven't learned but one thing it is that I have rights as a person. Thank you.

-I have recommended this class to friends and I hope they will participate and gain as much as I have.

-Interaction of women in assertiveness training is beneficial at all ages and in all walks of life. It is training which should be continued and refreshed throughout a woman's life.

Group III

-Very enjoyable. Would like to do further work.

-Guess I expected problems would diminish. Found, even though problems increased, ability to cope and "say my piece" also increased.

-How simple it was to solve a problem I had had for almost a year! Rehearsing on tape was very good. The next day, when I talked to the person I work with, I could not believe how calm my voice was and that I did not feel guilty for telling it like it was.

Group IV

-There were a lot of concepts I have been developing (ways to communicate effectively) that were reinforced by the class sessions. I appreciated the opportunity to write down and think and talk about various situations that I was confronted with. There were times when I felt bored and exasperated when concepts were not grasped by others. I felt uncomfortable expressing these feelings directly at the times because I was not in a "group" that was revealing feelings to each other - perhaps a different group could have been more so. I also knew that someone else may need to learn the concepts I felt so bored by. Anyway, on the whole I know that I am now thinking a lot more about being honest, open and direct as opposed to my easier more sarcastic modes. I am also feeling more confidence within myself which is a nice feeling. Thanks for your time and efforts.

-I feel it might have been better if it were at all possible - to have grouped similar people together with as much similar situation. It was hard or more difficult to relate to a group mostly composed of middle-aged nonworking wifes and mothers when I am a student divorced and going through experiences from the viewpoint of a totally different lifestyle and attitudes. I think maybe it would've been more fulfilling to be able to be in a group of women that have or are in similar circumstances - that way I think the group idea - of helping one another - learning from each other's experiences, etc. can be maximized. However, the group was very enjoyable and I learned a lot from the other women's experiences as well. I learned a lot of behavior patterns that were indicative of unassertive behavior - behavior which I had rationalized about before. I do not mean to put down the other ladies in the group at all - in fact I found most of them to be very nice. Sometimes it just helps to feel that other people are in similar situations and can feel the same way e.g. dating, problems of being on your own, etc. which these ladies don't have. It was however a very enjoyable class and I admire your efforts.

Group V

-I feel I have learned to know who I am once again and where I'm heading. This helps me cope with small problems as they come and not let them become big and out of hand.

-I would like to see this taught in the elementary schools. I feel it is important to a feeling of self-worth as well as harmony among groups of people.

-I really enjoyed the class because now I feel like I can cope with different situations assertively and not keep putting off people.

-I feel more at ease in my everyday situations because I am more aware of my feelings and better able to express them to myself and others.

-Though somewhat apprehensive the first two meetings, I have learned to be a little more open in stating my needs. I am a happier and more relaxed person now. You have helped me to be more careful with my assertions, that is less aggressive.

-This has helped me think more of myself and to let others know my true feelings.

Group VI

-Need more reinforcement to change habits. Do the wrong thing before I think of what I should have done.

-I have enjoyed this class and feel that I have learned from it.

-I have enjoyed this course very much. At times I felt we spent too much time in discussing personal problems. We tended to try solving others problems instead of dealing with assertive behaviors. However, I realize that this all helped us to relate to how assertiveness effects our own personal lives. I hope I am able to consistently use the techniques I have learned.

-I found the training helpful to me especially in this period of transition from marriage to single parent. The ideas and material were presented in a practical manner so that I felt comfortable in trying to apply them to my new home situation in relationships of total responsibility for children. In addition I began work after an interim as a homemaker. I was more readily able to assimilate myself into a different working environment. Thank you for your helpful suggestions, challenging "homework" assignments and opportunities to practice assertions in class. I am very grateful for your knowledge and your time.

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BIOGRAPHICAL SKETCH

Gertrude Gies Little was born on February 14, 1947 in Erie, Pennsylvania. She was raised in St. Marys, Pennsylvania. On June 12, 1975 she married George Walton Little, M.D. She now resides in Gainesville, Florida.

Ms. Little was graduated from the Grier School in Tyrone, Pennsylvania in May, 1964. In May, 1968 she received the Bachelor of Arts degree in Philosophy from St. Marys College in Notre Dame, Indiana. She began her graduate study in the Department of Counselor Education at the University of Florida the following September. She received her Master of Education and Specialist in Education degrees in 1971.

During her graduate work Ms. Little served as a resident assistant in the University of Florida residence halls and as a graduate assistant in both the Department of Counselor Education and the Department of Behavioral Studies at the University of Florida. She has taught Assertiveness Training from Women in the Community Education program at Sante Fe Community College for four years.

Ms. Little is a member of the American Personnel and Guidance Association and the American College Personnel Association.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Larry C. Loesch

Larry C. Loesch, Chairman
Associate Professor of
Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

David Lane

David Lane
Professor Emeritus, Department of
Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

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This dissertation was submitted to the Graduate Faculty of the Department of Counselor Education in the College of Education and to the Graduate Council, and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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